

**The concept of normality as a component of help
seeking and adaptation in couples with experience of
postnatal depression:
A grounded theory study**

By

Marlis A Bunyan ✓

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I certify that this thesis is the true and accurate version of the thesis approved
by the examiners

Signed ..



(Director of Studies)

Date...

11/06/08

Abstract

Postnatal depression is a significant challenge to the mental health of women of childbearing age. Partners and other family members are expected to provide support and care. This thesis extends the existing work to explore the experience of both partners in the couple relationship and to identify their related support needs. A series of joint and individual interviews with seventeen couples were analysed utilising components of grounded theory and the constant comparative method. Family systems theory informed the exploration of the relationship issues and the couples' support networks. The couples' definition of 'parenting normality' informs the two core processes, which detail the couples' help seeking and their progress towards recovery.

The partners identify similar support needs but emphasise some aspects of their experience differently. Both partners value their relationship and strive to maintain it during a challenging time. A number of considerations influence their help seeking and progress towards recovery. The couples express a need to understand the illness, the treatment options available and to receive consistent support from those around them. Social contacts, sharing the experience with others and the inclusion of the partner in the decision making process are helpful support strategies. Their expectations of themselves as parents and the stigma of mental health influence their help seeking. It is important that the individual has time to explore emotional issues with a trusted helper. Men are less able to share their feelings, often coping with significant emotional distress alone. Professionals play a significant role in supporting the woman, but are seen as less relevant to her partner.

Practitioners should identify strategies to reduce barriers to service access and explore opportunities for early interventions. A range of timely support options should be available to families, which are responsive to their needs and negotiated with all parties concerned.

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Volume 1 Chapters one to seven

Chapter 1 Introduction

1.1 Background

10-15% of women suffer from postnatal depression following the birth of a child. It is estimated that an average number of 6, 500 to 9, 500 women in Scotland are affected each year. The Scottish Intercollegiate Network Guidelines define postnatal depression as 'any non psychotic, depressive illness of mild to moderate severity occurring during the first postnatal year' but it 'should not be used as a generic term for all mental illness following delivery' (2002, pg 2). The range of symptoms experienced by women, reflect the feelings of anxiety and depressed mood associated with the condition. These can manifest themselves in a lack of interest, changes in appetite and sleep pattern, feelings of fatigue and irritability as well as feelings of worthlessness and guilt (Watson Driscoll 2006). The definition of postnatal depression therefore combines the elements of depressive illness, anxiety and the specific context of childbirth and parenthood, which characterise the illness. The symptoms, which inform the diagnosis of postnatal depression, have been described in detail in the main diagnostic manuals of mental health and disease and are listed in detail in appendix 1 of this thesis (World Health Organisation 2007, American Psychiatric Association 2000). Standard advice from health professionals includes the need for support and practical help from the partner (Morgan et al. 1997, Coffman et al. 1994, Stover and Marmejou 1995). Although this advice is repeated frequently, it is recommended that effective types of support should be investigated further (Ray and Hodnett 2001). Although male partners are seen as the main

source of support in the parenting relationship, they have little knowledge of postnatal depression and differ in their definition of suitable support for their partner (Coffman et al. 1994, George 1996). Little is known of the actual perceptions of couples and the support they normally offer each other (Mauthner 1998b).

Health policy has recognised the need for an integrated approach to the provision of care for individuals affected by postnatal depression (Scottish Executive 2004). Health care providers have addressed these recommendations with the introduction of local protocols and audit initiatives to identify gaps in service delivery (CPHVA 2001, Clinical Resource and Audit Group: working group on Maternity Services 1996). The focus of this work has been mainly on the woman and the need to support her in her recovery. This is in contrast to the professed holistic approach to care promoted by health professionals, which should acknowledge the patient within the wider context of family and society. Wright and Leahy's work on family systems nursing provides a useful model, which places the patient at the centre of care within a framework of relevant care providers (Wright and Leahey 2000). Although the experience of postnatal depression for women has been explored from a range of perspectives, little work has been done to explore the views of the identified main care giver. Where this is a male partner, the effect of the illness on the couple relationship, the partner's needs to enable him to manage the illness and the family's response to the challenges of the illness require further investigation.

This chapter provides an overview of the research problem, justifying the enquiry on theoretical and practical grounds. A description of my personal journey through the study illustrates the reflexive background to the work. In addition an overview of the approach to the study outlines the scope for the enquiry. This chapter allows the reader to gain an understanding of the main components of the thesis and their development.

1.2 The area of study

As our understanding of the impact of postnatal depression on the couple relationship and the support needs of the partners is limited, this study explores these aspects further in the context of the parenting dyad. It adds to existing knowledge and further informs the delivery of services for this client group.

The study is set in a mixed rural and urban area in the East of Scotland. A purposive sample of a heterogeneous group of seventeen couples with experience of postnatal depression was selected. As the experience of postnatal depression is likely to be very different for each couple, the sample included couples from both rural and urban backgrounds, with children of different ages and position within the family. Sampling thus was designed to identify the variety of views and experiences that exist, rather than to quantify them. Respondents were over sixteen years of age, had been diagnosed with postnatal depression by their general practitioner and treated for the illness on diagnosis. Health visitors and community mental health nurses in contact with the clients facilitated recruitment.

The area of interest, which informs this thesis, is the exploration of the experience of postnatal depression of couples in a parenting relationship and the identification of their support needs. The thesis essentially argues that this experience is very similar for both partners in the couple relationship, although each places a different emphasis on some aspects of this experience. The value both partners place on the relationship sustains them through the challenges of the illness. The respondents identify a number of considerations, which affect their help seeking and assessment of their progress towards recovery. Their definition of a concept of 'parenting normality' is central to these processes. These aspects of the study are linked to the wider theoretical framework of family system nursing (Wright and Leahey 2000) and the Leventhal common sense model of health and illness (Leventhal et al. 2003).

1.3 Justification for the research

A considerable body of literature has explored the experience of postnatal depression from the woman's perspective and stressed the need to support the woman at this difficult transitional stage of her life (Brugha et al. 1998, Chung and Yue 1999, Cutrona 1984, Levitt et al. 1986, Logsdon et al. 1994, Misri et al. 2000, Stover and Marmejoun 1995). The lack of information regarding the perspective of men, as fathers, has been commented on by some authors (Areias et al. 1996, Ballard 1996, Gabaud du Fort et al. 1994, Matthey et al. 2000). While men are frequently encouraged to support their partners, the impact of the illness on the men and the couple relationship,

requires further exploration. Men as carers have been identified in other fields of health research, in particular in the area of cancer care and chronic illness (Kroenke 2001, Soothill et al. 2001).

The majority of women suffering from postnatal depression are cared for in primary care and remain within their home environment (Scottish Intercollegiate Guidelines Network 2002). This places the burden of care on the woman's partner, who often balances his responsibilities in the home with those in the workplace and his own adjustment to fatherhood. Screening for postnatal depression is standard practice in many areas. Follow-up care for patients thus identified needs to be reviewed and coordinated more effectively (Scottish Executive 2001, Scottish Intercollegiate Guidelines Network 2002). This study focuses on the central parenting dyad. It adds the voices of the women and their partners to contribute their experience to the development of clinical practice. The findings from this study add to our knowledge of suitable support strategies informed by the families themselves.

1.4 The thesis as a developmental journey

The researcher is an integral part of the qualitative research process. My personal journey, the progression of the study from direct work with families to theory development, is integral to the understanding of the work. The project has spanned a number of years, the route changing and evolving during this time. The various components of the thesis reflect the personal and professional developments, which have occurred during the course of

the study. I have included reflexive comments at various points of this work where they make most sense to me and provide additional insight into my interaction with the data. Some are presented formally in chapter 4 on reflexivity, while others are part of the findings and their discussion.

My professional contact with families triggered the developmental journey of this thesis (figure 1).

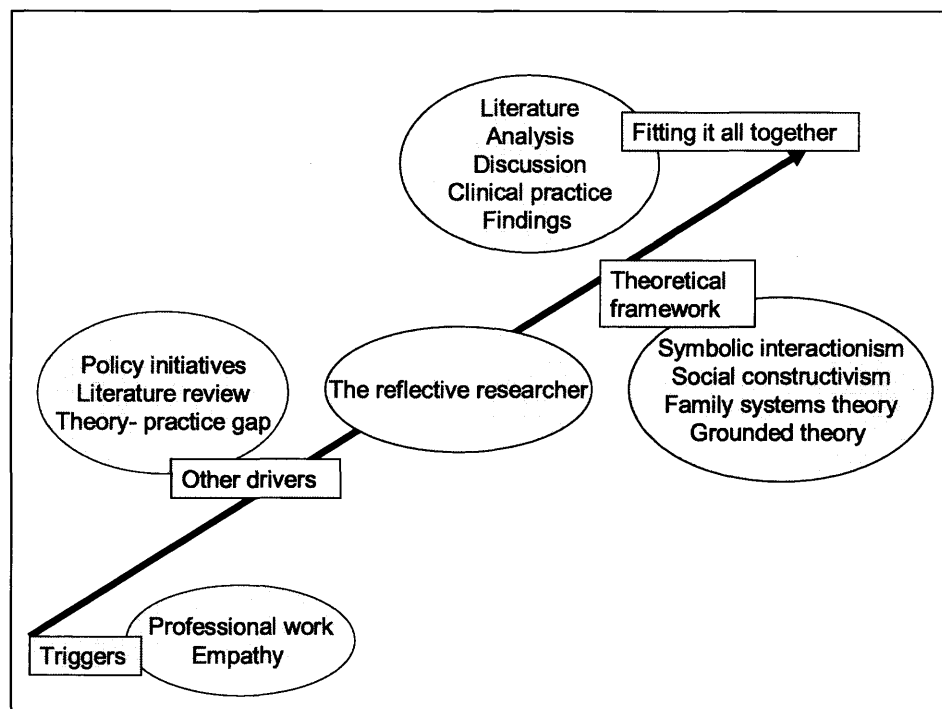


Figure 1 The thesis as a developmental journey

Other drivers moved the work on and developed it from a general interest in this area to a study specifically focussing on the needs of couples. The study is based on an understanding that our personal world is created in interaction with those around us, changes in response to our experiences and strives to achieve a state of equilibrium. This position informed my analysis of the data and my findings. Having started the journey of this thesis with a review of the

literature, I returned to it during my discussion of the findings. This fits with the grounded theory approach to analysis and positions the work within our current body of knowledge. My recommendations for clinical practice finally conclude the developmental journey of this thesis with recommendations for further research.

1.4.1 Triggers

I had worked with women suffering from postnatal depression as a health visitor in primary care for a number of years. During the early years of my professional practice, the condition had been recognised and was being discussed in the literature. However mechanisms to identify and offer systematic support to these clients were only just emerging. This highlighted for me the need to bridge the gap between the evidence base and clinical practice. I became involved in a number of local initiatives to develop services based on sound research evidence. An initial clinical audit highlighted a lack of coordinated services and differences in the assessment and treatment available to these clients. The report on maternal deaths (Clinical Resource and Audit Group: working group on Maternity Services 1996) and guidance from the Scottish Executive in the 1990s (NHS MEL 27 1999) provided welcome support to establish a coordinated approach to care for this client group.

As part of such a holistic approach to care, my colleagues and I recognised the impact of postnatal depression on the whole family. We asked a local couple to speak at a conference organised to promote the initiative. While the

woman attended and spoke movingly of her experience, her partner chose to have his account read out to the audience. He described his own distress and feelings of confusion. This incident remained in my mind long after the conference. It became the trigger for me to explore postnatal depression from the couple perspective and eventually led to this study, which commenced in 2001.

1.4.2 Other drivers

At the time of writing my first proposals and applying for funding, the literature suggested that a significant percentage of the population was likely to be affected by the illness. It recognised the impact of postnatal depression on the whole family, often for extensive periods of time. Particularly the effect of the illness on the cognitive development of the children, had been documented (Cooper and Murray 1998). In addition a correlation between depression in the partners and a relationship under stress became apparent (Areias et al. 1996, Morgan et al. 1997). Recommendations recognised the need for a coordinated approach to reduce morbidity through prompt detection and treatment in primary care (Clinical Resource and Audit Group: working group on Maternity Services 1996).

Professionals were advising families that practical support should be sought from the partner and family (Stover and Marmejoun 1995). Little information was available with regard to the format of this support and the couples' perception of this advice. A number of interested groups such as the Marce Society, the Association for Postnatal Illness and the Church of Scotland, had

been working in this field for a considerable time. Professionals in generalist clinical practice were only beginning to recognise the need to focus on postnatal depression as a matter of priority. The year after I embarked on my study, the Scottish Intercollegiate Network published its guidelines on postnatal depression, recommending a family approach to care by providers of clinical services (Scottish Intercollegiate Guidelines Network 2002). My interest reflected the emerging recognition of postnatal depression as a significant mental health problem impacting on the whole family. As the study progressed, new research in the area continued this trend.

Hence the exploration of the literature for this study occurred in two distinct phases. The first is presented in the initial review of the literature in chapter 2. This focuses mainly on the knowledge, which informed the proposal, the early background to the study and the research problem. The second is interlinked with the discussion of the findings from the study. This develops the earlier review of the literature in the light of the findings and positions the study within the current research agenda. Thus this thesis contributes to the emerging body of knowledge but also reflects how this has developed over the lifespan of this study.

1.4.3 The theoretical framework

I have utilised a number of theoretical frameworks and the grounded theory approach to the analysis of the data. My choice arose from my desire to find answers to questions, which could only be found in dialogue with those who knew; the couples themselves. This core concept of qualitative enquiry is

reflected in the symbolic interactionist perspective that individuals attempt to make sense of their world by constructing meaning through their interactions with those around them. They constantly re- evaluate their experience and gain self awareness from this exchange with the social world (Hewitt 1997, Meltzer et al. 1975). A qualitative approach to enquiry informed by symbolic interactionism helped me facilitate the exploration of these meanings with the respondents. It also recognises that new meaning is being co- constructed through the dialogue between researcher and respondent. In addition family systems theory is informed by symbolic interactionism and its interest in the socialisation processes of the family (Klein and White 1996). Family systems nursing (Wright and Leahey 2000) specifically recognises the social context and its impact on the family unit. It proposes that families function as self regulating units, which are interdependent and must be seen as more than their individual parts. The study's focus on the couple relationship allowed me to gain an insight into the functioning of one of the important subsystems of the family system and its interactions with the various other systems around it.

I sought to understand the perspective of the respondents, their social context and the social processes, which influenced their social interactions. Social constructivism and its search for 'verstehen' allowed me to acknowledge these various influences and recognise that each person constructs their world differently (Bryman 2001). My research does not aim to describe an objective reality but seeks to present the social reality of the couples I interviewed. Gaining an insight into their experiences informs the

comparison of their representations with those described by other authors. The use of grounded theory in the analysis of the data fits with these theoretical perspectives and my desire to gain a deeper understanding of the experience of the participants. I am particularly drawn to the iterative nature of this approach, which demands that the researcher attends closely to the data but also develops and tests emerging hypotheses. This helped me to remain embedded in the perspective of the respondents while constructing new meaning from the material generated through my interactions with the respondents.

1.4.4 Fitting it all together

My personal interest, the various professional drivers and the theoretical frameworks described above provide the background to this thesis. My choice of methodology and a qualitative approach to enquiry reflect my position. An understanding of the 'knowledge of the other' in the form of patients or recipients of professional care is desirable. It gives voice to the recipients of that care to achieve a better understanding of their needs to inform service delivery (McLeod 2001, pg 3). I therefore interviewed respondents in depth to explore their perspective in detail and gain new insights (Bryman 2001). Kvale (1996) proposes that the interviewer is an interested "traveller", who seeks to construct understanding through the process of conversation and reflection. As I sought to reach an understanding of the perspective of the couples a qualitative approach to enquiry provided an appropriate framework. I utilised aspects of grounded theory to analyse the data, abstract emerging concepts and develop a core

category and related processes (Glaser and Strauss 1967, Strauss and Corbin 1990). Clinical practice and my desire to develop our understanding of the needs of clients have been the drivers for this study and conclude the developmental journey of this thesis. It provides one stepping stone of many in the search for knowledge towards improved clinical care.

1.5 Thesis overview

The work is presented in a total of nine chapters. It begins by taking the reader from the introduction and general background of the study to a review of the literature current at the time of commencement of the study. The initial review of the literature in chapter 2 explores the background to postnatal depression, setting it within the context of peri-natal mental illness and depression. Management and treatment options for the illness are discussed, which focus particularly on medication and psychotherapeutic interventions. The review then proceeds to examine the context of care, its impact on a relative or partner and suggested support strategies for the carer. The review concludes with a short overview of gender roles and the specific support needs, which couples have during the transition to parenthood.

The principles of analysis and their operationalisation are discussed in chapter 3. Here the framework of qualitative research is defined and related to the concept of reflexivity as an integral component of this approach. Consideration is given to some methodological issues which potentially impact on the findings of the study. Grounded theory as the chosen method of analysis is described in detail. Chapter 4 returns to the concept of

reflexivity and explores in detail the various considerations, which inform the various stages of this study. Ahern's (1999) ten tips for reflexive bracketing provide the basis for the reflection described here.

The following three chapters describe the three stages of analysis and their related findings. Chapter 5 identifies the seven early category networks, which were developed from the identification of early themes during the first stage of analysis of the interview data. Chapter 6 develops these into two category frameworks in answer to the two research questions posed by this study. Finally, in chapter 7, the core category of 'parenting normality' is defined and related to two developmental processes, which chart the couples' response to postnatal depression and their transition to parenthood.

The concluding chapter 8 examines the findings in the light of the recent literature and how these could be applied to healthcare. Potential limitations are highlighted for consideration before suggestions for service delivery and future research are made. This chapter relates the findings of the study to the current literature and identifies the new knowledge, which has emerged. The chapter concludes with a final summary overview of the thesis.

1.6 Summary of the findings

The partners in the couple relationship identify similar support needs but emphasise different aspects of their experience. They both value the relationship, which sustains them through the challenges of the illness. A number of considerations influence the couples' help seeking and their

response to the illness. The partners' definition of the concept of a 'parenting normality' is central to these processes.

1.7 Conclusion

This chapter provides a justification for the thesis based on a literature, which focuses mainly on women, their experience of postnatal depression and an expectation that their partners support them. It is recognised that partners of postnatally depressed women are more likely to experience depressive symptoms themselves. There is a lack of knowledge about the impact of postnatal depression on the partners and the couple relationship. The research problem identified therefore relates to the experience of postnatal depression of parenting couples and the exploration of their support needs.

The work is justified in terms of an identified gap in knowledge and the need for professionals to understand the perspective of service users when developing health services. The insights gained through this study have the potential to inform clinical practice and support services for this group of clients. The methodology for the study is outlined briefly and justified on the basis that a qualitative approach to enquiry allows an in- depth exploration of the views of respondents. The utilisation of components of Strauss and Corbin's (1998) grounded theory approach provides a systematic structure for the work and leads the analysis towards the proposed core category and related processes. An outline of the various chapters, which contribute to this thesis, provides a short overview of the content and direction of the work. Finally, the scope for the study is outlined and related to its key concepts.

This introductory chapter provides the reader with a summary overview of the study and an early indication of the outcome of the work.

Chapter 2 Initial review of the literature

2.1 Introduction

This chapter reviews the literature to understand the factors associated with postnatal depression, its impact on families and recommended treatment options. It analyses the background to the present study and provides a justification for the chosen methodology.

Current UK healthcare provision increasingly recognises the impact, which postnatal depression has on the health and well being of women of childbearing age. Early identification and treatment are important to improve the early parenting experience of families and minimise the impact on the children (Scottish Executive 2000a, 2000b, 2003a, 2004). Thus the context of the partner and the whole family are increasingly being acknowledged. Furthermore postnatal depression needs to be considered from the wider perspective of parenthood, family roles and the care of individuals suffering from a mental health problem.

This review sets the condition into the context of the wider social and gender issues, which are likely to impact on the respondents' experience. The specific attitudes of men and women towards childcare and the care of a partner with postnatal depression are further explored. Family systems nursing recognises that families do not function in isolation (Wright and Leahey 1999, 2000). This model provides a theoretical framework to understand the interaction between the family unit and the wider social world.

Postnatal depression poses significant challenges for the affected families and the providers of health care for this client group. While the literature reveals a wide range of studies, which have explored women's experiences of postnatal depression, we know very little about the perspective of both partners in the parenting relationship. Theoretical and methodological considerations are explored in more detail later in the methodology chapter (chapter 3) of this thesis. Here the knowledge, as it was available at the inception of this study, is explored. The more recent literature is discussed and related to the findings of this thesis in chapter 8. This approach reflects the iterative process of discovery inherent in the study and sets the work within the current knowledge framework.

2.2 Defining postnatal depression

10-15% of women suffer from postnatal depression following the birth of a child. It is suggested that most women have a 'normal' reaction to childbirth, which is characterised by a range of emotional responses to motherhood. These settle spontaneously and result in an adjustment to the role and contentment with the new responsibilities. The woman with postnatal depression may be left with an unsettling experience often lasting beyond the first year (Holden 1996).

Postnatal depression is defined as 'any non psychotic, depressive illness of mild to moderate severity occurring during the first postnatal year' (Scottish Intercollegiate Guidelines Network 2002, pg 2). Women experience a range

of symptoms, which are listed in detail in appendix 1 of this thesis (American Psychiatric Association 2000, World Health Organisation 2007). These reflect the combined challenges of feelings of anxiety and depressed mood associated with the condition and the specific context of childbirth and parenthood. (Watson Driscoll 2006). Any definition has the inherent problem, that a differentiation between postnatal depression and depression can be problematic. For instance postnatally depressed women exhibit fewer suicidal feelings but experience higher levels of fatigue and feelings of guilt (Terry et al. 1996). However postnatal depression is delineated from the other two depressive disorders which occur during the period following childbirth: puerperal psychosis and maternity blues (Terry et al. 1996, Holden 1996).

Postnatal depression is often characterised by an outward display of normality (Pritchard and Harris 1996). This can mask the true incidence of the illness prompted by a fear of shame. Small et al. (1994) conducted a population based survey at 8-9 months postnatal followed up by interview 12-18 months later. Most subjects in this study identified themselves as depressed, but 33% did not want to label this experience as postnatal depression. Only 40% of these women had sought help from professionals, while 50% had sought help from non- professional sources, mainly their friends. Although a small study, which followed up only 45 women from an original sample of 115 women, it suggests that the condition is under diagnosed. Professionals are not always likely to be involved in the care of these women, leading to a possible higher incidence than expected. Their findings reflect those of an earlier qualitative study by McIntosh (1993),

where only 25% of the women interviewed had sought help from a professional. More recent work also suggests that the continued underreporting of postnatal depression is due to the stigma of mental illness (Mantle 2001).

Medical descriptions of postnatal depression often focus on the signs and symptoms of the illness. Such a focus reflects the biomedical model of health and disease which has dominated Western medical practice since the middle of the 19th century (Sarafino 2004). While it has contributed to our understanding of specific disease processes at the biological level, it does not fully explain the complexity of people's illness experience and the factors which affect their recovery. The model interprets disease as an independent occurrence which can be recognised by specific signs and symptoms. It makes the patient the passive recipient of a disease process which is perceived to be a deviation from the 'normal' of health (Atkinson 1988). When disease is interpreted in this manner it implies that 'normality' is defined by others rather than the patient (Mishler 1989). Medicine in this model occupies a position of neutrality which is outside the common social sphere. Nevertheless it is used as a justification for medical practitioners to make judgements about the individual. The legitimacy of such a position opens it to criticism and has been disputed by a number of writers (Williams 2003).

From a biomedical perspective mental illness is interpreted as a malfunction of the brain which can be corrected by medication. Hereditary factors also play a role in the development of mental illness in this model (Crossley

2000). This interpretation of depression relegates any psychosocial issues to the background and ignores important aspects of the patient's experience (Rowe 2006). Conversely the evidence to support a purely biomedical explanation for depression still needs to be presented convincingly. For instance treatment approaches based solely on pharmaceutical interventions have not been demonstrated to be effective (Rowe 2006).

Often patients themselves find it easier to accept a biomedical explanation for their illness (Crossley 2000). Acknowledging the influence of non biomedical factors can potentially blame the patient for the illness and place the onus for recovery on the individual. In this case, accepting a biomedical explanation for an illness like depression shifts the responsibility for its management from the person to circumstances outside their control. At the same time it places the person in the position of helpless recipient of medical care (Karp 1996). Rowe (2006) picks up on this theme and encourages people suffering from depression to engage actively with their experience as part of their recovery.

The biomedical model has been criticised for its inability to provide a full explanation for the development of ill health or the process of recovery from disease (Sanderson 2004). Engel (1977, 1980) and Schwartz (1982) in particular have identified these shortcomings and proposed a more integrative model which includes both biomedical and psychosocial explanations. How our understanding of postnatal depression is informed by these different perspectives is discussed in more detail below.

For instance feminist authors (Nicolson 1998b, Lewis and Nicolson 1998, Mauthner 1999) reject the medical model of postnatal depression altogether. They argue that postnatal depression can be attributed to social causes. Women need to experience, express and validate the feelings, which are associated with the transition to motherhood. They require supportive, accepting and non-judgemental interpersonal relationships as well as an appropriate cultural context to achieve this. The illness reflects a lack of such opportunities. In particular, the relationship with her partner and others can affect the woman's response to this process (Mauthner 1998a, 1999). Postnatal depression is thus a social construct rather than an illness in need of treatment. However the claim that a medical model of postnatal depression stigmatises and blames the woman for her difficulties, is rejected by others (Pritchard and Harris 1996). It is acknowledged that the individual woman's experience should be interpreted within the context of her social world. The medical model here contrasts with the social model of postnatal depression, which requires a reinterpretation of motherhood. Becoming a mother should be recognised as a social event to be valued by society rather than a medical event, caused by a biological dysfunction (Nicolson 1998a).

The sociological concept of embodiment offers a further perspective on postnatal depression. It occupies a intermediate position between the biomedical explanations offered above and the socially focussed approach proposed by feminist writers like Nicolson (1986). Bodies are integral to daily life since they allow people to interact with their social world and to manage

relationships (Shilling 1993). The body is not a simple collection of biological functions but is shaped by a range of social processes. It is integral to people's understanding of their world and shapes their interactions and experience (Woodward 2002). This position emphasises a link rather than a dichotomy of mind and body. Meaning is created by the interaction of the two components. By placing the meaning of the human experience in the body it is also placed in the world (Williams and Bendelow 1998). People are thinking bodies that make sense of the world around them through their interaction in an embodied world (Woodward 2002). The current position that unhappiness and dissatisfaction with life are due to a personal fault in the individual can often ignore the realities of the social world and a perception that this world is uncontrollable (Williams 2003).

A definition of depression as an embodied experience questions the biomedical explanation of illness with its focus on a failing body. It recognises the interaction between body and mind and considers it within the social and political context of the definition of mental illness (Lee 1999). The embodied contextualisation of depression has been highlighted by Burr and Chapman (2004) who suggest in their study of South Asian women in the UK that the bodily representation of depression is reflected in the physical symptoms but also in the individual experience of the women and their social context. For these women a material, bodily representation of their complaints increases the legitimacy of their complaints and facilitates access to medical services. Postnatal depression in particular lends itself to a physical embodiment and a more legitimate explanation of their experience. Families are more likely to

focus on the embodied representation of postnatal depression, such as fatigue and the difficulties of settling a wakeful child. A perception that a mental illness like depression represents an unacceptable weakness reinforces this emphasis on the physical aspects of the condition (Tammentie et al. 2004). Particularly hormonal explanations of postnatal depression reflect such an embodiment of mental distress in the physical body and reinforce an internal attribution of distress (Ussher 2006).

In contrast, body problems are often interpreted as problems of the self which need to be resolved holistically rather than only physically. Illness is embodied not only in the physical symptoms of disease but becomes a concern for the whole self (Karas Montez and Karner 2005) and a central consideration for our understanding of mental health and wellbeing (Williams 2003). People fluidly move between the different aspects of mind, body and social world to make active sense of their experience (Waskul and Vannini 2006). An interpretation of mental illness as a physical condition fails to acknowledge this interrelationship between mind and body. It ignores the impact of mental illness on the individual's behaviour and feelings (Rudge and Morse 2001). However, even if a mainly biomedical explanation is rejected, most explanations need to be considered carefully since they can reinforce an understanding of postnatal depression as an illness, caused by a deviant body, which needs to be regulated through a medical process of diagnosis and treatment (Ussher 2006).

Explanations of postnatal depression range from biomedical explanations such as hormonal changes to socially constructed explanations which focus on the impact of social role changes on the lives of women. An understanding of depression as an embodied experience situates it between the physical and the social explanations by recognising the interaction of body, mind and social context. These aspects are reflected in the holistic model proposed by Milgrom et al. (1999) who suggest a similar interplay between individual and social factors as causes of postnatal depression.

The incidence of postnatal depression is frequently compared with that of clinical depression. Early estimates by Paykel et al. (1980) suggest an incidence of 20% for postnatal depression, which is reduced to 10-15% when the stricter Research Diagnostic Criteria are applied (Spitzer et al. 1978). Nicolson (1990) increases this estimate to 24-30% to reflect underreporting. Overall, 5-15% of the population suffer from depression at some stage in their lives, often more than one episode (DePaulo and Horvitz 2002). This suggests that the incidence of postnatal depression does not differ from that of the general population.

These discrepancies illustrate the difficulties associated with the definition of each of the conditions, which have generated a significant discussion. Clinical depression and postnatal depression are not different conditions but are only distinguishable in their severity (Whiffen and Gotlib 1993). Postnatal depression is less severe, is influenced by a previous history of depression and likely to resolve within six months. Similarities rather than differences

were identified in a comparison of women with postnatal depression and other depressions. When they were assessed by psychosocial variables such as interpersonal relationships, stress and coping, postnatally depressed women reported better marital relationships and less severe depression than their peers. No other differences between the two groups were found (Whiffen and Gotlib 1993). Similarly a large prospective, longitudinal study undertaken in Germany by Kurstjens and Wolke (2001) found little evidence to distinguish the two conditions with regard to severity or precursors. As their study did identify a significant correlation between depression and psychosocial and family stress factors, their findings support aspects of a social model of depression.

These perspectives differ from the large area of research, which represents postnatal depression as a specific female condition. Its link to the postnatal period differentiates it in terms of lower suicide risk, high anxiety levels, lack of sleep due to the care needs of an infant and milder symptomatology (Hiscock and Wake 2001). Riechler-Roessler and Hofecker (2003) argue strongly that the separate terminology of postnatal depression should be retained. They stress that women have to confront some very specific problems such as a fear of stigma, late help seeking and the difficulties of an accurate diagnosis. Based on the understanding of postnatal depression as a distinct condition, Holden (1991, 1996) and Beck and Gable (2001a, 2001b) developed specific screening tools. The Edinburgh Postnatal Depression Scale was developed with the specific aim to achieve increased sensitivity

and relevance for women suffering from postnatal depression compared to the more generic Beck's Depression Inventory (Beck et al. 1961).

The medical model of postnatal depression has informed studies investigating the link between postnatal changes and the physiological causes of postnatal depression. These have attempted to attribute the illness to the method of feeding, the woman's hormone levels and traumatic birth events (Campbell and Cohn 1991, Creedy 1999, Huang and Mathers 2001). None clearly do identify a link and are often drawn to speculate about the influence of other, non-physiological factors, such as socio- economic or cultural conditions.

The social model of postnatal depression interprets the condition as a poorly managed family crisis caused by a maladaptive interactional system (Kraus and Redman 1986). Cox (1986) expands on this perspective and suggests that postnatal depression reflects the complex challenges faced by women at this stage of their life. The social impact of childbirth as a significant life event is thus recognised as 'a cluster of events, some of which are losses associated with an altered relationship with a partner or with a loss of social role' (Cox 1986, p 38). Oakley (1979) coins the term 'the postnatal depression syndrome' in her writings, highlighting the complex set of factors, which can influence women's experiences of childbirth and the outcome. Her past and present life events, her personality and the context of her life at the time of birth affect the woman's experience of motherhood (Holden 1991). In

addition the role of life stressors in the development of the condition should be acknowledged when women are assessed (Tennant 2002).

This overview illustrates the complex issues, which have been raised by the attempts to define postnatal depression and understand its causes. Although the debate has been ongoing for a considerable time, a conclusive outcome has not been reached so far. Two positions have emerged, which represent the end points of a continuum. One places postnatal depression in the domain of an illness, which requires medical intervention. The other explains the condition as a social event, which reflects a response to the complex challenges posed by a significant life event. Despite feminist contentions that a medicalised understanding of postnatal depression does not recognise the wider context of the woman's life and her social experience, clinical management guidelines emphasise the need to consider both medical and psychosocial interventions (Scottish Intercollegiate Guidelines Network 2002).

2.3 Management and treatment

The treatment options reflect the range of suggested causes. These fall into three main categories:

- Hormonal causes and the treatment of an underlying hormonal imbalance
- Anti- depressant medication to treat the depressive illness
- Counselling interventions to address psychosocial issues

It is possible that some women may be more sensitive to the sudden drop in progesterone levels after birth and develop postnatal depression (Holden 1991). The value of hormone therapy to treat these women requires further investigation. While oestrogen therapy particularly in severe postnatal depression (Gregoire et al. 1996) may be of benefit, the evidence for the use of progesterone therapy is not convincing (Granger and Underwood 2001). In addition hypothyroidism occurs commonly in these women. They may benefit from treatment to alleviate any thyroid symptoms, which may exacerbate mood changes in the postnatal period (Pritchard and Harris 1996). Thus the evidence base for hormonal treatments is scant and excludes them as a first line treatment.

Instead, current clinical guidelines recommend the use of anti depressant therapy for postnatal depression and a management approach similar to that of other depressions (Scottish Intercollegiate Guidelines Network 2002). Ironically, the efficacy of these drugs specifically in postnatal depression has been little researched. A systematic review of the effectiveness of antidepressant treatment undertaken by Hoffbrand et al. (2001) highlights this gap. In a comparison of various prescription drugs with other forms of treatment and their potentially adverse impact on the nursing baby, only one trial was sufficiently robust to support the use of the anti depressant Fluoxetine. Although this medication was as effective as a full course of cognitive therapy, the authors identified the need for more trials with a longer follow-up period, comparing drug treatments and psychosocial interventions. Some complementary therapies have also been suggested for women

uncomfortable with the use of prescription drugs (Mantle 2001) but these should be used with caution. Concerns remain, which relate to their safety and the robustness of the supporting evidence (Scottish Intercollegiate Guidelines Network 2002).

Following on from hormonal and antidepressant therapy, various counselling interventions comprise the third approach to treatment. These range from health visitor listening visits to psychotherapeutic techniques such as cognitive behavioural therapy and psychotherapy. Holden (1996, 1991) championed the use of health visitor listening visits, which contribute to recovery by creating a safe, non-judgemental environment. In addition these contacts increase the likelihood for women to seek medical treatment (Holden et al. 1989). Despite some methodological concerns, Holden's (1989) work has influenced professional practice considerably since its publication. Later comparisons of different psychological interventions conclude that listening visits can be as effective as more structured cognitive behavioural therapy. None has more than a limited effect on maternal mood or mother- child interaction beyond the first nine months postpartum (Cooper et al. 2003, Murray et al. 2003).

Such intervention should be part of an appropriate treatment package, which recognises the complexity of the condition. Feminist authors in particular, warn that postnatal depression often only becomes a problem when it is defined and treated inappropriately (Nicolson 1990). Counselling interventions provide an additional care option. However the evidence for

some of these interventions has been criticised. For instance a review of the efficacy of generic counselling and cognitive behaviour therapy offered by general practitioners to patients suffering from depression identified five studies (Churchill et al. 1999). Their poor methodology and insufficient follow up led the reviewers to caution against the use of counselling interventions as a sole mode of treatment. Overall counselling can improve the outcome for patients cared for in general practice. A Cochrane review by Rowland and Bower (2001) for instance explored outcome data for patients with psychological and psychosocial problems. Four trials with a total sample of 678 patients were identified and indicated high levels of satisfaction. All four studies raise some methodological concerns and offer little information with regard to the cost effectiveness of this type of treatment. The review highlights the need to recognise patient satisfaction as an additional quality indicator to assess the value of a treatment.

The available evidence suggests that various forms of listening and counselling interventions are used extensively and provide an additional treatment option. However the evidence base is limited and requires large scale studies of robust design. Clinical guidelines suggest that women with postnatal depression are treated with antidepressant medication in a similar way as other patients with depression. Care providers need to consider the specific needs of pregnant and breastfeeding women. Psychosocial interventions are recommended as part of a package of care (Scottish Intercollegiate Guidelines Network 2002). This reflects the literature, which

cautions against the indiscriminate prescription of counselling as a sole form of treatment, but acknowledges its acceptability to patients.

Milgrom et al (1999) have developed a bio-psychosocial model of postnatal depression which incorporates all of these elements into a treatment framework. Their approach is based on systems theory and Engel's (1980) recognition that an effective intervention should address the individual's specific combination of biological, psychological and sociological factors. Their holistic model of care acknowledges these and reflects the complexity of postnatal depression. Their model describes four aspects of care, which need to be considered:

- Vulnerability factors, which occur prior to pregnancy and determine susceptibility
- Precipitating factors, which occur around the time of birth and trigger the illness
- Exacerbating and maintaining factors, which are maladaptive reactions by the woman and significant others and
- Socio-cultural factors, which contribute to the psychosocial context of postnatal depression (Milgrom et al. 1999, p 26).

Treatment should 'equip women with skills to make positive changes in a range of different areas of their lives' (Milgrom et al. 1999, p 28). This approach addresses not only a range of behavioural responses but also acknowledges the influence of the woman's various social relationships. These four factors therefore reflect the complexity of the experience of

postnatal depression and set the illness within the wider social context of the family.

2.4 Context of care

The needs of carers of individuals suffering from mental health problems have been emphasised in the National Service Framework for Mental Health as a major standard for the delivery of services (Thornicroft 2000, Department of Health 1999). The emerging voices of carers increasingly influence policy in the United Kingdom and Europe (Brand 2001), stressing the need for professionals to involve carers in service planning (Butterworth and Rushforth 1995). The link between the burden of care and increased levels of depression is reflected in a range of stress related conditions experienced by carers. Carers require support to alleviate the stress caused by caring for a dependent partner or other member of the family (Lowery et al. 2000, Goldstein et al. 2000, Douglas and Spellacy 2000, Ip and Mackenzie 1998).

The effect of caring on the carer has been explored from the perspective of a wide range of conditions such as Dementia and Alzheimer's Disease (Donaldson et al. 1998, Jackson et al. 1991, Brodaty and Hadzi-Pavlovic 1990, Saad et al. 1995, Ballard et al. 1996, Fuh et al. 1999, Lo and Brown 2000, Lowery et al. 2000), chronic mental illnesses such as Schizophrenia and Bipolar Depressive Disorder (Brooker 1990, Carson and Manchershaw 1992, Shepherd et al. 1995, Musee et al. 1996, Horsley et al. 1998, Ip and Mackenzie 1998, Pejler 2001) and chronic physical illnesses such as

Multiple Sclerosis and Motor Neuron Disease (Hakim et al. 2000, Goldstein et al. 2000). In addition carers of individuals suffering from the effects of injury (Knight et al. 1998a, Douglas and Spellacy 2000, Perlesz et al. 2000, Harris et al. 2001, Morris 2001a), cardiac surgery and cancer are in need of support (Davies 2000a, Hart 1989, Davies 2000b).

While these studies explore a range of very diverse conditions, they identify two common themes: women frequently act as the main carer and they benefit specifically from social support to alleviate the stress of caring for a relative (Boeger and Pickartz 1998a, Boeger and Pickartz 1998b, Knight et al. 1998b). Often this support is offered in the form of information about the condition. This alone is unlikely to reduce the stress levels experienced by the carer (Davies 2000b, Kelleher and Mannix 2001, Morris 2001a, Sutcliffe and Lerner 1988). It should be enhanced by the provision of additional strategies to strengthen the carer's coping resources and their emotional support (Beck and Minghella 1998, Carson and Manchershaw 1992, Winefield et al. 1998, Simmons 1994, Saad et al. 1995).

The stress created by the burden of caring affects the mental health of carers negatively and is reflected in increased levels of depression (Knight et al. 1998b, Douglas and Spellacy 2000, Lowery et al. 2000, Jones et al. 2000, Harris et al. 2001, Ballard et al. 1996). For instance both male and female carers of individuals suffering from dementia display increased level of stress and depression (Braekhus et al. 1998, Saad et al. 1995).

Although the relationship between caring and depression appears to be significant, other authors question this link. They suggest that the relationship is more complex than a direct link between caring and depression. It is likely that it is also influenced by the carer's own health and existing coping responses. Furthermore, distress with the caring situation can be expressed in other ways such as anger and symptoms of fatigue (Knight et al. 1998b, Knight et al. 1998a). Interestingly, a surprising number of carers manage a stressful caring situation successfully and display no differences in depression from non care givers (Knight et al. 1997, Perlesz et al. 2000). Even these authors identify a link between dissatisfaction with or a lack of social support and increased carer stress. Social support for the carer is therefore desirable as it can alleviate the stress of the caring activity (Beck and Minghella 1998, Kua 1989). Support from family and other informal sources is welcomed by most carers and can contribute to an increased quality of life (Schneider et al. 2001, Carson and Manchershaw 1992, Winefield and Harvey 1995, Sutcliffe and Lerner 1988). These studies highlight the impact, which the care of individuals suffering from a range of conditions can have on the mental health and well being of the carer. The carer, who is often the partner or a close relative, can benefit from social support.

Sufferers and carers value the various support strategies differently. For instance carers of schizophrenia sufferers value financial help and medical advice. They also want help to monitor their relative's treatment and symptoms. In contrast, the patients themselves appreciate practical help

such as support with housing, finances and employment more (Shepherd et al. 1995). Carers need personalised information to help them care for their relative, a point highlighted specifically in relation to carers of women with postnatal depression (Gutteridge 2001).

Information giving alone is insufficient to relieve the stress of caring (Kelleher and Mannix 2001, Simpson 1999). A study of Dementia carers notes that this only achieves an increase in knowledge rather than a reduction in stress levels (Sutcliffe and Larner 1988). Strategies to support carers fall into two different categories: information giving and emotional support. The latter can be provided either informally from family members or formally through counselling. Regardless of its source, emotional support can reduce stress, anxiety and depression in the carer (Kelleher and Mannix 2001, Gunstone 1999, Carson and Manchershaw 1992, Winefield and Harvey 1995, Sutcliffe and Larner 1988, Kua 1989).

Health professionals are increasingly aware of the need to consult individuals and their carers and involve them in decision making. This requires that professionals actively seek out the views of carers and involve them in staff training (Department of Health 1999, Department of Health 2000). Although informal carers are in need of support, they should also be recognised as experts and partners in the care of the person they are caring for (Simpson 1999). The range of studies identified above identifies common themes important for a range of informal carers. Less is known about the needs of families caring for women with postnatal depression. It is likely that the need

for information but, more importantly, for support is just as relevant for these families. In addition families need to manage the demands of a new baby and a young family while negotiating the challenges of a mental health problem. Their perspective is of interest for professionals providing care to this group of clients.

2.5 Gender roles

The transition to parenthood is a challenging time for women but also stressful for the men in the couple relationship (Rholes et al. 2001, Simons et al. 2003). Women face a significant adjustment to their life style brought about by the changes in their personal circumstances and the responsibilities of care for a newborn child. Their partners are perceived to be on the periphery of this process, not engaged and unwilling to support their partner during this period of adjustment. This brings considerable stress to a relationship where the expectations of support are not met by the woman's most intimate partner (Berthiaume et al. 1996).

Furthermore, the experience of both partners is embedded in their social environment. The partners' actions are guided by social expectations and role demands (Hock et al. 1995). They may see their roles differently or feel pressure to comply with a role, with which they may not necessarily feel comfortable. For instance the men are expected to balance the role of a supportive father with the demands of the workplace and other obligations outwith the immediate family environment (St John et al. 2005). In contrast, women identify the triple demands of childcare, household chores and work

commitments as the major challenges of their role. They perceive their partners to be less affected, experiencing little change and limited engagement with childcare and household chores (Nicolson 1990). A number of studies focus particularly on the burden of care placed on new mothers and the women in the family (Harwood et al. 2007, Mercer 2004, Nicolson 1990). Furthermore, the men's process of transition to parenthood is beginning to be recognised (Webster 2002, Davey et al. 2006). It is possible that differences in role expectations can lead to stress and tension between the partners.

Men are affected by the transition to parenthood and the added responsibilities for the family. This is significant for their own mental well-being, the stability of the couple relationship and the welfare of their children (de Montigny and Lacharité 2004, Elliott et al. 2000, George 1996, Rholes et al. 2001, Simpson et al. 2003). Men are expected to provide support to their partners and are often cited by the women as their main source of support (Besser et al. 2002, Leathers et al. 1997, Madsen 1994). Their partner's support contributes significantly to the women's well being and their own adaptation to motherhood (Börjesson et al. 2004, Hock et al. 1995). A lack of assistance from the partner can add to the woman's levels of stress. Satisfaction with support such as childcare and emotional encouragement can be helpful (Cox et al. 1989, Crnic et al. 1983).

Men and women thus agree that men are important to the well being of the family unit. They differ in the extent to which they actively take on childcare

responsibility. On the whole, mothers are the main care giver for the infant. Fathers are involved on the periphery but often more positive about their relationship (Cappuccini and Cochrane 2000, Cox et al. 1999). It is important to understand how the men understand their role and adjust to it in the context of their new family. It is likely that couples, who have to manage the additional challenges posed by postnatal depression, experience a more complex process of transition to parenthood. These couples also face the additional uncertainty of mental illness, the need for the woman to receive often intensive support and an expectation that her partner will provide this support. Postnatal depression from the woman's perspective is well understood. How it affects the male partner, and how he negotiates this additional complexity in his transition to fatherhood, is less well understood (de Montigny and Lacharité 2004, Gage et al. 2006). It is useful to explore the perspective of both partners and their expectations of support.

2.6 Social support

Social support specifically identifies the resources, which individuals can access from others in their social network (Walker 2001, Sarason et al. 1987, Simmons 1994). Its main aspects relate to informational- and practical help, emotional support and reassurance (Chung and Yue 1999). Social support and marital satisfaction are predictors of postnatal depression in the prenatal- and the early postpartum period (Chung and Yue 1999, Cox 1986). It should be noted that a lack of social support predicts but does not cause postnatal depression (Murata et al. 1998). In addition the expectation rather than the actual support received is more significant in the development of depressive

symptoms. For instance women with overtly optimistic expectations of support are more susceptible to depressive symptomatology than women with more realistic expectations (Harwood et al. 2007).

Couples organise their relationship on a basis of mutual support and an understanding of equity for the partners. A perception that the household workload is shared equitably contributes to a feeling of wellbeing in the relationship. This persists regardless of any inherent power differential in the relationship. The mental health of women, in particular, is positively affected by such perceptions (Willigen and Drentea 2001). Social support is a significant factor associated with the development of postnatal depression and an individual's response to stressful life events (Beck 1996, Beck 2001, Berthiaume et al. 1996, Kendall - Tackett and Kantor 1993, Zeidner and Endler 1996).

Most of these studies focus on the women's perception of social support. Whether the men see this in similar terms is debateable and has only been investigated by a few authors (Gage et al. 2006). There does appear to be a decline in the support, which men offer to their partner during the postnatal period. This contrasts with a perception that men are never able to support their depressed partner sufficiently (Rholes et al. 2001, Simpson et al. 2003, St John et al. 2005). Men face a potential conflict when they try to offer support to their female partner. While they are expected to balance the conflicting demands of work and family life, men are also seen as the main source of support for the women. Fathers comment that they have a desire to

be involved in the care of their infants and the family but do tend to engage differently from the women.

While both men and women appreciate emotional support, men are more likely to offer practical help. Women judge their partner on his ability to provide emotional assistance (de Montigny and Lacharité 2004, Leathers et al. 1997). In addition women seek out other sources of social support beyond their partner (Baker and Taylor 1997, Besser et al. 2002, Madsen 1994). Their needs also change and develop as the number of children increases. Women with first babies benefit from group support, while women with more than one child tend to favour individual support activities (Elliott et al. 2000).

In general supportive relationships for individuals suffering from mental distress are characterised by emotional support, companionship and practical support (Kendall - Tackett and Kantor 1993). While this applies also to women with postnatal depression there is a difference in the value, which men and women place on these activities (George 1996). Women focus on emotional support and feel unsupported if this is not provided. Men are more likely to focus on practical support. This difference in emphasis can cause tension in the couple relationship and lead to marital dissatisfaction (Harwood et al. 2007). The transition to parenthood is a challenging time for both partners, which is further stressed by the distorting effect of postnatal depression on the woman's self esteem and her expectations of motherhood. It is increasingly recognised that both partners are affected by the transition to parenthood. The views of both partners need to be taken into account to

plan care for this client group. How couples negotiate support from each other and their wider social network requires further exploration.

2.7 Conclusion

Postnatal depression not only causes significant distress to the woman but also to her partner and the whole family. Health professionals encourage partners to support the woman and offer her practical help (Morgan et al. 1997, Coffman et al. 1994, Stover and Marmejoun 1995). Although this advice is repeated frequently, little information is available to define the meaning of the term to the couples involved. It is recommended that the most effective types of support offered to the woman should be investigated further (Ray and Hodnett 2001). Both partners are affected and can potentially benefit from support (Sheppard 1997, Seguin et al. 1999, Leathers et al. 1997).

Men are under considerable stress when they provide support to their partners. This can contribute significantly to a rise in tension between the partners and in the relationship (Morgan et al. 1997). Although male partners are seen as the main source of support in the couple relationship, they have little knowledge of postnatal depression and differ in their definition of suitable support for their partner (Coffman et al. 1994, George 1996). Little is known of the actual perceptions of couples and the support they normally offer each other (Mauthner 1998b).

It is timely to recognise the needs of both partners in the couple relationship. Both partners undergo a process of transition to parenthood, which is characterised by changes in the relationship. Postnatal depression acts as an additional stressor for new parents at this crucial time. Women's support needs have been recognised and are being promoted by a number of agencies. The voices of both partners in the relationship need to be heard to support young families effectively and respond to their needs. This study focussed on the following areas: the experience of postnatal depression for male and female partners in the parenting relationship and their support needs and networks.

Chapter 3 The principles of analysis and their operationalisation

3.1 Introduction

This chapter explores the methodology used in the current study. The theory which informs qualitative research in general and the use of grounded theory in particular are discussed. Reflexivity and trustworthiness of the findings from qualitative enquiry are considered. An overview of the study's design is provided. This is followed by a detailed discussion of the philosophical considerations and main concepts of grounded theory. The analysis of the work utilises the steps and tools identified by Strauss and Corbin (1998) in their approach to grounded theory. They facilitate the systematic analysis of the data and are illustrated with examples from the current study. This chapter presents an overview of the principles of analysis and their operationalisation. In addition consideration is given to some specific methodological issues. These include aspects of sampling through gatekeepers, the implications of joint interviews for the collection of data, the use of mapping to chart the respondents' support networks and the issue of respondent validation. These points are highlighted here to provide a detailed overview of the approach to the analysis and to explore specific application issues important to this particular study.

3.2 Defining the framework of qualitative enquiry

The aim of science is 'the methodological production of new, systematic knowledge' (Kvale 1996, pg 60). Qualitative approaches to enquiry are used

increasingly in the social sciences, educational and health research. An understanding of the 'knowledge of the other' (McLeod 2001, pg 3), the patients or recipients of professional care, is desirable. It gives them a voice and makes their needs clearer to those professionals, who design and deliver clinical services.

An important focus of qualitative enquiry is the exploration of the accounts of people's lives and their experience. It seeks to understand social behaviours (Avis 2005) through the extensive interaction with people, the utilisation of textual data and an approach to enquiry based in the naturalist setting. Denzin and Lincoln (2005) suggest that qualitative research constructs a social reality, which is developed from the intimate relationship between the researcher and the area studied. How experience and meaning are created are key questions.

The aims of qualitative and quantitative research are sometimes said to be at each end of a 'bad' and 'good' spectrum of research (Silverman 2001). This perspective can lead to a destructive tension between the two approaches. It fails to recognise the unique contribution, which each methodology can make to the body of knowledge. Silverman (2001) suggests that it is more useful to understand qualitative and quantitative research as two different perspectives, which emphasise different aspects of knowledge construction. In this respect the main strength of qualitative enquiry is its ability to shed light on social and cultural constructions.

Constructing knowledge of the social world brings its own tensions with it. An interpretive framework informed by Max Weber's concept of 'verstehen' (Weber 1947, Schwandt 1998) stipulates that the researcher sees through the eyes of those studied, is aware of their social context and places an emphasis on social processes (Bryman 2001). As the social world is constructed of multiply realities, the researcher seeks to uncover these through enquiry set in the natural world. A debate surrounds this interpretivist understanding of the world, which refutes the existence of an objective social reality (Charmaz 2000, Schwandt 2000). It has been questioned as unproductive, denying the concurrent existence of an objective social reality. Both can be discovered and make a contribution to our understanding of the same phenomenon (Avis 2005).

The in depth interview is a common method of qualitative data collection. It allows the interviewer to explore the perspective of the respondents in detail and discover new issues not previously considered (Dicicco-Bloom and Crabtree 2006, Bryman 2001). The interviewer's own perspective can be either as a neutral observer 'mining for gold nuggets' or an interested 'traveller' seeking to construct an understanding through the process of conversation and reflection (Kvale 1996). The role of the qualitative researcher is central to the process of analysis. The researcher is integral to the collection and subsequent interpretation of the material (Denzin and Lincoln 2000). Such immersion in the data facilitates the in depth exploration of the material, the identification of likely relationships and the formulation of

hypotheses: 'analysis is the interplay between researchers and data' (Strauss and Corbin 1998, pg 13).

As the researcher aims to reach a deeper understanding of a phenomenon, the approach to qualitative analysis proposed by grounded theory is inductive and seeks to generate a theoretical understanding of the phenomenon (Glaser and Strauss 1967). Such a one directional outcome has been criticised as being too simplistic, ignoring the iterative nature of the analytical process. The constant comparative method and the search for deviant cases are key elements of this process of enquiry (Fielding 1988). Strauss and Corbin (1998) developed this argument further and stressed the need for induction as well as hypothesis testing. Their approach thus recognises the need for interpretation and provides a systematically sound basis for it (Strauss and Corbin 1998). There is a fundamental difference between grounded theory as advocated in the early writings of Glaser and Strauss (1967) and the later work of Strauss and Corbin (1998). Grounded theory can thus be interpreted as either a general framework to support the systematic process of enquiry or a more prescriptive set of analytical tools to generate sound theory.

A considerable body of qualitative work has been informed by the principles of grounded theory. In particular the approaches to sampling and coding, the constant comparison of the data and the search for deviant cases have been used extensively (Bryman 2001). There is a need though to recognise the

individuality of each data set and the need to apply the principles of the method flexibly (Strauss and Corbin 1997).

This study has been informed by some of the above considerations and the need to apply the tools of grounded theory sensitively. The main aim of the work is the need to demonstrate a rigorous approach to data collection and analysis to meet the requirements of the public research community (Snape and Spencer 2003). A position of realism has been adopted, which recognises the existence of an independent social reality only accessible through the respondents' interpretation of the world. Some aspects of the scientific method are subscribed to, which relate to the importance to demonstrate objectivity and neutrality, while recognising that the personal perspectives of the researcher affect the interpretation of the findings. Both reliability and validity are recognised as important and attainable in an effort to reach trustworthy findings. A social interactionist perspective is adopted, which aims to explore the experience of the study's participants. Grounded theory as an approach to analysis lends itself to this type of enquiry. It provides tools to identify analytical categories and explore their relationships. It facilitates the production of a theoretical framework to explain social processes (Charmaz 2000). The current study follows the analytical steps proposed by grounded theory such as theoretical sampling, the constant comparison of the data and the various stages of coding (Glaser and Strauss 1967, Strauss and Corbin 1998) to support the systematic analysis of the data as well as the development of a substantive theory to inform the delivery of healthcare services.

3.3 *The issue of reflexivity*

In the search for a rich description of the respondents' experience, the researcher is integral to the process of enquiry but must adopt a reflective stance. This needs to demonstrate the researcher's theoretical position, professional background and personal biases, which shape the work (Dowell et al. 1995). Such a reflective approach ensures that the researcher acknowledges the shared nature of the understanding created through the interaction between researcher and respondent. It recognises that both the researcher and the participants bring their own experience and background to the construction of this shared knowledge (Nicolson 1998b). Particularly the creation of medical knowledge has been criticised for a lack of empowerment of the research participants and the presentation of expert driven theories. A reflective approach to scientific endeavour challenges the claim of impartiality of this expert knowledge and gives voice to the individual experience in its full complexity (Mitchell 1996).

The researcher needs to be aware of the two dimensions of reflexivity (May 1998) to understand the interaction between science and the social world. Endogenous reflexivity identifies the social knowledge common to all individuals. In contrast, referential reflexivity specifically seeks to address the issues raised by the process of research, which tries to understand another social world constructed through the interaction between researcher and participant. The latter, in particular, is important to sensitise the researcher to the wider implications of the research, the construction of expert knowledge and the process of dissemination of the knowledge generated (May 1998). It

is important to guard against the potential danger that the researcher's inward focus on reflection becomes its own objective in a process of infinite regression 'of reflections on reflection' (Gergen and Gergen 2003, pg 580) which potentially changes the nature of the enquiry (McLeod 2001).

The qualitative researcher needs to balance two potentially conflicting aims: the truthful representation of the respondents' experience and the exclusion of the researcher's personal background and social world from this representation. One strategy to address this dilemma has been proposed by Ahern (1999). He suggests a ten step approach to 'bracket' personal bias and to reduce its influence on the research process. The researcher needs to identify areas of interest, personal issues, personal value systems, potential role conflicts and the interests of gatekeepers. These issues need to be revisited regularly and considered specifically at various junctions in the process. Ahern's (1999) criteria thus provide a useful systematic framework to maintain a reflective awareness and delineate the various perspectives. Chapter 4 (reflexivity) explores the various considerations, which influence the current study in detail.

3.4 Grounded theory

Grounded theory aims to generate theory out of research data by achieving a 'close fit between the two' (Bryman 2001, pg 503). Glaser and Strauss proposed their method in response to criticism that research based on qualitative material lacked a systematic approach to analysis. Grounded theory links data collection, analysis and theory together through an iterative

process of induction and deduction (Glaser and Strauss 1967). Increasingly abstract categories are identified, which seek to amalgamate the data and propose new relationships (Chamberlain 1999).

Qualitative theory has the potential to 'get at the messiness of reality'. (Morse et al. 2001, pg 236), which can aid our conceptual understanding of patients' experiences and related care processes (Chamberlain 1999). A 'pure' grounded theory approach is difficult to achieve due to continuing modification in the light of recent writings and an evolving body of studies using this approach (Bryman 2001, Bluff 2005). Although it is acceptable, deviations from the original systematic pathway need to be clarified and justified to the audience (Cutcliffe 2000).

3.4.1 Philosophical considerations

Glaser and Strauss came to the analysis of qualitative material from two very different perspectives (Strauss and Corbin 1990). Strauss was influenced by the American philosophy of pragmatism, which emphasises the need to closely link theory with practice and utilise knowledge as a means of organising experience. A symbolic interactionist understanding, that individuals are active participants in their attempt to create meaning of their world, informs Strauss' approach (Schwandt 1997, Silverman 2001). Meaning is fluid and dependent on the social situation of the individual. The researcher needs to make contact with the field to interpret the personal reality of the individual (Strauss and Corbin 1990). This perspective

recognises the wider influence of social factors on the social interaction of individuals (Annells 1996).

In contrast, Glaser's personal background led him to reject an overtly positivist approach to the analysis of the data. He emphasises the need to focus on the conceptual aspects of the material and their grounding in the data (Strauss and Corbin 1990). Glaser proposed in his later writings that the approach to grounded theory developed by Strauss and Corbin is in itself too formulaic and prescriptive: it forces theory rather than allows it to emerge from the data (Glaser 1992). He stresses the need for grounded theory to be used more flexibly than implied by Strauss and Corbin.

The method of analysis proposed by Glaser and Strauss is one of a number of interpretive forms of enquiry based on a given researcher's perspective (Rennie 2000). Respondents are individuals and thus agents of their situation. They may choose to be selective in their representation, misrepresent or not disclose significant aspects of their experience to the researcher. The process of interpretation includes two perspectives: the individual respondent's and the researcher's. Strauss and Corbin (1998) view their work from an interpretivist perspective. Objective knowledge can be constructed but needs to be understood as the product of the researcher's interpretation. Its transient nature arises from its temporal and location specific context.

Charmaz (2000) argues that grounded theory as an approach is inherently positivist. Its underlying assumption is the existence of an objective, external reality, which can be discovered by a neutral observer. The enquiry results in the eventual reduction of the data, which are presented in an objectivist format. Grounded theory also contains elements of a post-positivist stance when it is utilised to give voice to and represent the respondents' views. Strauss and Corbin's (1998) emphasis on reflexivity in the interpretation of the material further illustrates their move towards a post-positivist stance (Charmaz 2000).

In addition Avis (2003) points out that the key aim of any methodology should be rigour rather than the accurate representation of the human experience. The positivist approach, which bases its credibility on a set of rules to link knowledge with the evidence from the senses, is not appropriate for qualitative work. The latter aims to explore a different set of conditions: the human experience. Using a set of fixed rules does not recognise the fact that the interpretation of the evidence is itself derived from shared meaning. Avis (2003) takes this argument one step further: failing to acknowledge that diverse as well as common beliefs exist is too narrow a perspective. While the search for an absolute truth is futile, the enquirer can seek to interpret the world and present this explanation as a basis for discussion. Any such interpretation should meet the criteria of a good fit between the data and the beliefs and social theories accessible to us (Denzin and Lincoln 2000, Kvale 1996, Strauss and Corbin 1998). The findings from qualitative research need to be judged against their wider social context as well as the application of

methodological theory. In this case a systematic approach and specific analytical tools become the means for the researcher to access the information. On their own, they are not a justification for the validity of the findings (Avis 2003).

The debate around the nature and process of grounded theory identifies particularly issues of sampling, reflexivity, the use of literature and rigour of application (Cutcliffe 2000). This presents the researcher faced with the task of description of grounded theory with a dilemma: the identification and selection of the method's core features. These fall into two categories: the tools used and the outcomes (Bryman 2001). They will be described as they have been integrated into the overall process of analysis in the current study.

3.4.2 The tools of grounded theory

Grounded theory employs a number of tools, which are used consistently despite the otherwise often confusing discussion around the philosophical background to the method. These can be narrowed down to four components (Bryman 2001): theoretical sampling, coding, the constant comparison of the data and the saturation of the data.

3.4.2.1 Theoretical sampling

Theoretical sampling is integral to and guided by the process of data collection, its coding and concurrent analysis. The researcher utilises each of these aspects to identify 'what data to collect next and where to find them' (Glaser and Strauss 1967, pg 45). The adequacy of the sample is judged by

the width and diversity of the groups to achieve a rich description. Theoretical sensitivity develops gradually as the researcher becomes immersed in the data (Strauss and Corbin 1998). Sampling occurs during the various stages of the analysis and is informed by a range of conceptual frameworks. As the key research instrument, the researcher also draws on intuitive knowledge of the subject and the interaction with the respondents to explore the data and follow through on leads. A range of approaches are used to identify relevant sources of information. These draw closely on the data but also the wider subject context.

The terminology of purposeful sampling has been introduced by later writers, who suggest that all sampling is purposeful (Patton 1990). The researcher should provide a clear description of the sampling strategy to avoid confusion (Cutcliffe 2000). 'Purposeful sampling involves the calculated decision to sample a specific locale according to a preconceived but reasonable initial set of dimensions. In contrast, theoretical sampling has no such initial calculated decisions' (Cutcliffe 2000, pg 1477).

Sampling in qualitative research seeks to gain the depth perspective of informants with relevant experience of the area under investigation. It continues until saturation has been achieved and allows the researcher to revisit and explore issues as they emerge. This provides an ongoing opportunity to check the authenticity of the analysis and the emerging theory. Theoretical sampling further keeps the researcher in touch with the data and provides an additional means of improving ideas and concepts. Therefore

sampling has two purposes: it represents the underlying conceptual framework of the study and stresses the link between the data and the emerging theory (Charmaz 2000).

Sampling in the current study was purposeful to identify a diverse group of informants able to draw on a range of experiences of postnatal depression. Maximum variation sampling across a diversity of individuals has two advantages. Each case is described in great detail and is of potentially high quality. When shared patterns are identified across the range of cases, they gain in significance due to the diversity of the sample. Variations as well as significant common patterns within that variation can be identified (Patton 1990).

Seventeen couples participated in the study. Their age, area of residence and number of children informed the selection. The conceptual framework for these criteria was the literature on postnatal depression, information from interested workers, personal professional experience and the informants themselves. The experience of postnatal depression was likely to be very different for each couple. The support networks of first time parents and those with other children were potentially different. Location in a rural or urban environment was possibly implicated in access to support services. In addition the age of the child at interview reflected the proximity of the couple to the actual experience. The sampling strategy aimed to identify the variety of views and experiences of this group of individuals.

Once these criteria had been established, approval from relevant local research ethics committees was sought and obtained. Potential respondents were then approached through local health care and voluntary workers in contact with women and their children.

The final sample included first and second time parents of varying ages from both rural and urban areas (Table 1). Short narratives for each of the couples are provided in appendix 2. These offer a short summary of the respondents' background and their personal journey through postnatal depression. All couples lived in the East of Scotland, in both rural and urban settings. Eight couples were living in a rural environment, while a further nine couples lived in urban settings. The fathers' ages ranged from 24 to 42 years of age with an average age of 33 years. The mothers' ages ranged from 18 to 41 years of age with an average age of 32 years.

All, but one, of the fathers were in paid employment. Three men worked in managerial positions in medium sized local companies. Nine men worked in professional or associate professional and technical occupations such as engineering, health care and protective services. Three men worked in skilled trade occupations in agriculture and the construction industry. One man worked as a telephone sales person in a local call centre. The youngest man, Jason, had never worked and was on long term unemployment benefit. The women were divided into those working at home as home makers or childminders (8 women) and those working in a range of professional, associate professional, trades and personal services occupations (9 women).

Most of the respondents (12 couples) in the sample belonged to the top three occupational groupings. The remaining five couples could be classified as belonging to groups five and seven. The sample reflected a range of occupational groups but with a greater emphasis on managerial and associate professional occupations (12 couples). Six couples had one child, nine couples had two children and two couples had three children. Not all had experienced postnatal depression after the birth of all of their children but had at least encountered it with one child. Some mothers had been diagnosed within 2-3 months of birth. Others had reached the end of their child's first year of life before they received a diagnosis. The average age of the child at the mother's diagnosis was approximately 15 weeks.

At the time of the first interview with the couples, the illness was a very recent event for some couples. For instance Olive had been diagnosed seven weeks previously. For other couples, the first episode of postnatal depression had occurred seven years previously. The average time, which had elapsed between the experience of the illness and the interviews with the couples, was approximately two years and three months. The subsequent analysis of the data utilised this demographic information to examine the couples' responses for patterns based on age, social background, geographical location and time since diagnosis. Tables to illustrate this patterning are included in the subsequent chapters of findings.

Couple	Partners' names	Mother's occupation	Father's occupation	Occupational classification	Place of residence	Age of mother	Age of father	Number of children	Age of child at diagnosis	Time since diagnosis
C1	Aileen and Alan	Beautician	Engineer	2	Rural	30	35	2	2 weeks	14 weeks
C2	Barbara and Bert	Secretary	Joiner	5	Rural	30	32	2	4 weeks	17 months
C3	Carla and Chris	Teacher	Police officer	3	Rural	29	27	3	2 months	4 months
C4	Dana and David	Nurse	Technician	3	Rural	35	36	2	4 months	18 months
C5	Evelyn and Edward	Homemaker	Nurse	3	Urban	36	35	3	1 year	7 years
C6	Frances and Freddy	Homemaker	Police officer	3	Urban	41	42	2	10 months	6 years
C7	Gina and George	Homemaker	Nurse	3	Rural	32	28	2	7 months	3 years
C8	Hannah and Harold	Homemaker	Corporal	3	Rural	26	31	1	3 months	21 months
C9	Irene and Ian	Homemaker	Technician	3	Rural	26	28	2	4 weeks	2 years
C10	Jane and Jason	Homemaker	Unemployed	unemployed	Urban	18	24	1	4 weeks	5 months
C11	Karen and Kurt	Gardener	Gardener	5	Rural	30	31	1	2 months	3 months

Couple	Partners' names	Mother's occupation	Father's occupation	Occupational classification	Place of residence	Age of mother	Age of father	Number of children	Age of child at diagnosis	Time since diagnosis
C12	Lena and Len	Childminder	Business Development Manager	1	Urban	41	35	2	10 months	16 months
C13	Maureen and Mike	Nursery Nurse	Customer Services Consultant	7	Urban	24	30	1	1 month	3 months
C14	Nancy and Norman	Nurse	Production Manager	1	Urban	29	30	1	2 months	2 years
C15	Olive and Oscar	Nursery Nurse	Joiner	5	Urban	35	34	2	4 weeks	7 weeks
C16	Pam and Paul	Administrator	Engineer	2	Urban	37	38	2	2 months	22 months
C17	Rachel and Richard	Homemaker	Manager	1	Urban	39	40	1	4 months	7 years

Table 1 Respondent characteristics

Occupational groups have been allocated following the Office for National Statistics Classification (Office for National Statistics 2000)

Sampling continues beyond the initial selection of potential respondents into the actual process of interviewing and beyond this into the analysis of the data as they evolve (Strauss and Corbin 1998). Early interviews with the respondents were guided by a short list of interview themes, which were informed by the literature on the subject of postnatal depression and support (appendix 3). This allowed me to remain focussed on the subject and move the interview forward to the next area of interest. It also gave space to the respondents to expand on relevant issues of concern.

The themes and concepts emerging from this process in turn informed the subsequent interview questions and helped to develop my theoretical sensitivity. For instance the respondents used the term 'normality' frequently. In the context of the interviews, this appeared to indicate a measure of illness as well as recovery for the couples. Subsequent interview questions were adjusted to explore the emerging issues in more detail. Transcripts from previous interviews were also examined in the light of this new information. Strauss and Corbin (1998) stress the need to return to previous data. In this way concepts can be discovered, which may have been overlooked previously or link to the new data. I used both purposeful and theoretical sampling strategies. Purposeful sampling was used to select potential respondents. Theoretical sampling became more relevant at the interview and analysis stages. This reflects the process of qualitative research where often studies utilise a purposeful sample at the beginning. This aims to select participants with knowledge of the issues and reflects the theoretical position of the researcher. As emerging concepts are developed, sampling is further

influenced by the developing theory emerging from the analysis (Silverman 2000, Williams and Healy 2001, Bluff 2005).

3.4.2.2 Coding

Coding is closely linked to sampling. It simplifies the material and facilitates the retrieval of data segments for further analysis. Codes enable the researcher to notice and group examples of similar relevant phenomena together. Common patterns and differences can be identified and built together meaningful structures (Coffey and Atkinson 1996b). Although part of the analytical process, coding should not be confused with actual analysis. It sets the stage for the identification of data, their interpretation and allows conclusions to be drawn (Miles and Huberman 1994). Coding fragments the data and provides the first step toward abstraction of the material from its context. While the meaning of the data is retained, new relationships between the codes can be developed by reconstructing the material at a different level of understanding (Tesch 1990). It is important that the researcher keeps coding as close to the text as possible to prevent contamination of the data by existing theory or the researcher's belief systems (Charmaz 2000).

Three distinct types of coding in practice are described: open coding, axial coding and selective coding (Strauss and Corbin 1998, Strauss and Corbin 1990). Open coding allows the researcher to identify concepts embedded in the data and understand their properties and dimensions through a process of de-contextualisation. It can be performed at various levels of data from

line-by-line to sentences or paragraphs of text to whole documents (Bryman 2001, Strauss and Corbin 1998). Concepts identified are grouped to form new, more abstract categories. An understanding of their properties and dimensions can then be developed through the use of axial coding. This enables the researcher to re-contextualise the data broken down in open coding, linking actions or patterns to develop new connections. Once categories have been identified and their dimensions and properties explored in depth, they are integrated to form a central concept. This abstract core category should explain as wide a variation of the phenomenon as possible, provide a logical link for the various categories (Glaser 1978, Strauss and Corbin 1998) and explain a central process (Chamberlain 1999).

Although criticised by Glaser as 'forcing' theory through a ritualistic, formalised set of procedures (Glaser 1992), this procedural framework has become the more accepted version of Glaser and Strauss' original approach (Bryman 2001, Flick 2002). In addition Strauss and Corbin's (1998) more structured approach increases the credibility and dependability of the method (Miles and Huberman 1994).

Before I started to code the data in the current study, I undertook an initial thematic analysis to gain a broad overview of the key issues and to become immersed into the data. I examined the transcripts initially for units of meaning. These allowed the sense of the data to be contained within its immediate context and relevance to the respondents (Rennie 2000). Given the large number of interviews conducted within a relatively short time, this

early thematic approach to the analysis supported the theoretical sampling of the data during the ongoing interviews with the respondents. I was able to identify early gaps and fill these during subsequent interviews. For instance the first interview with Lena and Len highlighted a tension between Len's sense of exclusion and Lena's need for personal space. I was able to explore this potential conflict with each partner during subsequent interviews (appendix 3). The early themes uncovered in this manner allowed me to handle the data more effectively during the subsequent detailed analysis.

Although grounded theory stipulates that interviewing and analysis are undertaken concurrently, organisational and time constraints determined this adaptation. It did however facilitate the handling of a large amount of data within a short time frame, provided an early overview of the material covered with the respondents and helped structure the next stages of the analysis more effectively. The units of meaning were allocated general labels. Some reflected the literature on postnatal depression and common professional terms such as:

Acceptability	Assessment.
Causality	Compliance
Confidentiality,	Control
Coping	Counselling
Couple conflict	Disempowering
Emotional factors	Family dynamics
Gender issues	Geography
Group dynamics	Guilt and loss
Model	Needs
Physical factors	Resources
Social issues	Stigma
Stories about PND	Symptoms
Worker role	

Table 2 Professional terminology informing early codes

Others had been used by the respondents and subsequently became in vivo codes:

Activate own resources	Taking the tables
Fallen through the net	Fix it
Keeping up appearances	

Table 3 Lay terminology informing early codes

It is important to acknowledge the origins of these labels from the literature, personal professional knowledge and the respondents' own words. This knowledge can be incorporated into the work and avoid claims to an unobtainable position of objectivity (Ahern 1999, Kvale 1996, Morse 2002).

Subsequent open coding focussed particularly on the areas of interest of the current study. Some additional factors emerged during this process, which were related to the illness process, treatment choices, to gender and to relationship issues. All were grouped into tentative categories with related subcategories (table 4). There is the potential during the early stages of coding to code every text of some interest. Some may not be strictly relevant and prove to be unproductive. The researcher should remain open to unexpected developments and interpretations not originally anticipated (Strauss and Corbin 1998). Managing the challenge between the need to remain focussed on the area of interest and to be open to new issues emerging from the analytical process is of ongoing concern.

Category	Subcategory
Attitudes	Keeping up appearances, judgemental, life experience, own upbringing
Psychological issues	Culture, economics, environment, psychological effects on the carer, the children, the individual
Baby/ childcare related issues	Effect of the baby, childcare break, breastfeeding/ feeding
Sources of support	Male partner, female partner, extended family, friends and the informal network, groups, professionals
Support types	Listening, counselling, talking, and practical help with the children, the housework, and time out
Information needs	Leaflets, talking to professionals, talking to family/ friends, media, parenting preparation
Illness process	Causality, Ante- natal period, recovery, coping
Treatment	Medication, counselling, listening visits, secondary care in hospital or by CPN, self-help
Gender issues	Male role, female role, as wife, as mother, as husband, as father
Roles	As wife, as mother, as father, as husband, as professional, as voluntary worker, as patient
Relationships	Husband, wife, extended family, friends, professionals and informal networks

Table 4 Emergence of tentative categories and subcategories

Following early thematic and open coding a significant number of units of meaning had more than one code attached to them. I returned to the text to check for similarities and differences in the allocation of these codes and their meaning. Similar codes were combined to form summary codes (table 5). These helped to rationalise them, abstract the data further and inform the subsequent development of some tentative hypotheses.

Summary code	Developed from a range of codes
Different people for different functions	Diagnosis, doctor, family dynamics, family support, good dynamics, happy families, making a difference, non prescription drugs, outsider, professionals, treatment complementary, treatment medical
Helplessness and frustration	Couple conflict, couple problem, distancing, effect on carer, father, good husband, helplessness, needs partner, partner's interest,
Normality/ abnormality-	Baby factors, barriers, believes, causality, crisis, cultural factors, EPDS, expectations, recognition process, sick role, symptoms

Table 5 Combining early codes into summary codes

This review of the original codes also generated a number of specific in vivo codes, which had not been developed initially but helped to capture the perspective of the respondents more vividly:

"I am ok as long as she gets better"	"I didn't realise how ill she was"
"Keeping it in the family"	"On the back boiler"
"Putting a face on"	"She is not the same person"
"Whose problem is it?"	"Why us?"

Table 6 In vivo codes generated by respondents

It could be argued that these steps forced the data into my framework and failed to let the data guide the analysis. To avoid this possibility, I reviewed the text associated with the above summary codes line-by-line. This micro analysis helped me to seek out hidden meaning in the data and search for interpretations not immediately obvious during a broader approach to analysis (Strauss and Corbin 1998) The following example illustrates this process (table 7):

C8-PF; 016-034)

PF: I think so. For some reason, postnatal depression seems to just, I felt it seemed to take over every aspect of your life, where if you have other stresses, personally I would just say, I don't know, with my husband being away, that's like one part then the rest of my other life sort of stays the same but with postnatal depression it was just, it seemed to just swallow everything up. It was just... I don't know why I wasn't able to cope with the sort of as well as I would cope with; I mean I cope quite well with other things. It just, it seems such a huge thing. I think because your hormones are such (background noise from baby) all over the place and it's... I don't know why I didn't deal with it as well as I did anything else. Maybe it's cos your, I think a lot of pressure is put on you for sort of cos of different people coming in to your house and the whole focus was on sort of the baby and you know the baby is where the postnatal depression stems from so you know I presume it was because it was so, such an issue all the time. Everybody is asking about the baby and they'd keep asking about your baby. I don't suppose you can get away from it. I don't know if that's right. I'm not sure. I don't know.

Table 7 Example of micro analysis

This extract raises, among other concerns, issues of uncertainty. These were explored and summarised in the related memo (table 8). The link between text and codes develops when the researcher examines the ideas, which the codes have triggered, and writes these down. Reflexivity facilitates insight and a theoretical understanding of the information at hand. Memos help to chart theoretical thinking (Hammersley and Atkinson 1995) and support a sense of confidence in the analysis (Charmaz 2000). Different forms of memos fulfil different functions. For instance the early memos used in the current study were exploratory and described the ideas generated by the respondents' comments (Strauss and Corbin 1998). Later memos combined open-, theoretical- and operational elements in a mixed approach. These issues then informed theoretical sampling for subsequent interviews and the ongoing analysis.

"I think so"- uncertainty throughout this section, speculation about the issues discussed, a searching for answers which are not clear and can not be defined properly "for some reason" also about this uncertainty-

Flip flop to what happens if happiness rather than postnatal depression takes over your whole life- is that a problem or what is it about PND that makes it a problem when it takes over your life- would even permanent happiness have a destructive influence on your life?

"EVERY aspect of my life" is a real problem since it seems to be invasive and inescapable. Would it still be problematic if it only incurred occasionally rather than every aspect? The pervasiveness of postnatal depression is striking when compared to other stresses in her life, which don't seem to have the same impact. Interpretation of the situation vs. an attribution of them to other causes- see Leventhal's model of self regulatory behaviour "cope"- why is NOT being able to cope a problem? Relative aspects of coping could be explored here such as from her own perspective; that of others and what is normal vs. what is abnormal coping. "Pressure is put on you" a visibility, being observed by others, having a child moves the woman into the public eye with everybody free to comment on her actions and her behaviour- is there a link here to her perception of coping and not coping i.e. how others judge her is essential to how she judges her own coping, how she meets these expectations from those around her but possibly also from within herself.

"Baby is where postnatal depression stems from" social vs. physical causes- is she just referring to the physical causes here? But then later she implies being trapped and caught in the situation "I don't suppose you can get away from it" therefore a more social component of the postnatal depression and the perceived causes for her here "I don't know if that is right" is this here in an I am correct or in a moral sense? Why are hormones somehow more acceptable as a cause for postnatal depression? Throughout a sense of speculation, trying to make sense of the causes and what is happening to her.

Table 8 Example of micro analysis memo

A number of early themes were identified through open- and line by line coding. These were grouped to link the codes and propose a number of category networks. I chose to represent them in diagrams (figure 2) adapted from the tools available in the qualitative data analysis software Atlas/ti (Scientific Software Development 1997), which reflected my own preference for the use of mind maps to explore abstract connections (Buzan 1974).

Narratives attached to the networks helped to formulate working hypotheses. Seven category networks were developed and formed the first stage of the analysis (chapter 5).

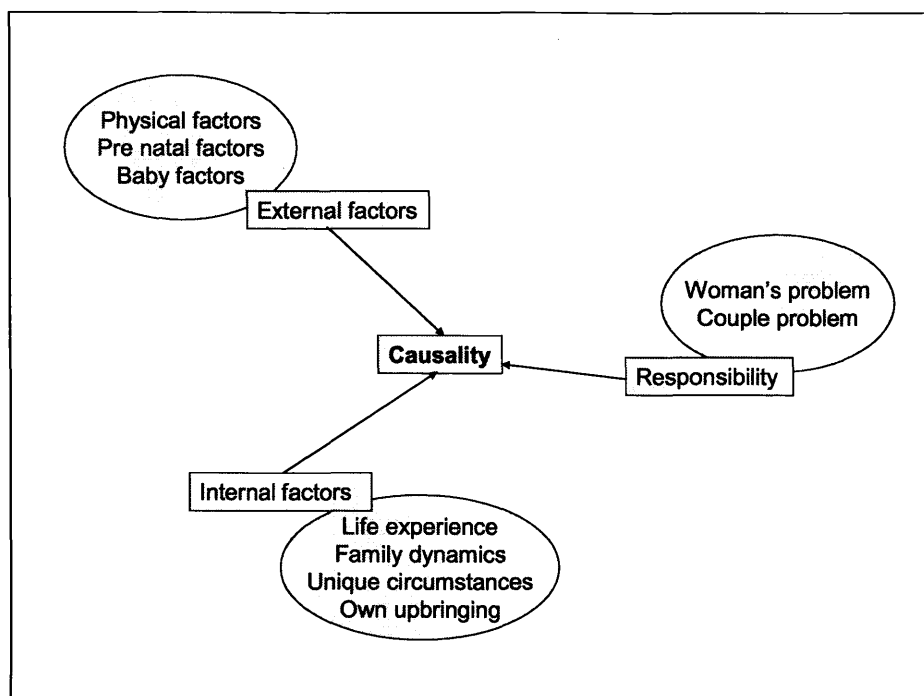


Figure 2 Example of conceptual map

The development of categories and related narratives facilitates the systematic exploration of concepts and encourages questions about potential relationships (Strauss and Corbin 1998). Any attempt at conceptualisation is inherently analytical since it carries a deductive element of hypothesis testing with it. The constant comparison between the data and the emerging concepts is central to this interpretative process.

Linking codes with similar meanings and developing categories from these, leads to a more abstract understanding of the data (Strauss and Corbin 1998). Each category has characteristics, which are likely to be constructed along a continuum (Bluff 2005). The dimensions for each category need to be

developed to gain a deeper understanding of its width and breadth. The flip-flop technique is one of the strategies to facilitate this process. It allows the researcher to step back from the data and explore the information from a different perspective. The researcher asks questions to draw out other aspects of meaning than those immediately obvious to the reader. The researcher asks: "what if the opposite was the case?" and seeks to open new avenues of enquiry. The technique can help the researcher discover new meanings and develop specific properties in more detail (Strauss and Corbin 1998). This was used on a number of occasions and, in particular, during line-by-line coding. For example the flip-flop technique raised the following questions in the current study:

Jason, interview 3

Just the same as normal. I'm getting drained by having my attention split. On one side I've got a baby that needs all the attention and then on the other side, I've got my poorly partner that also needs my attention because she's poorly and I'm finding it hard to spread myself around.

MEMO

"Same as normal"- what is normal? What happens if things are not the same?

"Drained"- washed out, exhaustion, element of defeat, down a plughole- all negativity- loss of something- is this energy getting drained or his emotions? What happens if he is not drained and instead full of energy? Would this affect the way he feels about the situation and her illness?

Table 9 Example of application of the flip-flop technique

This raised issues of the definition of 'normality' and its possible dimensions. In subsequent interviews, I was able to explore these issues in more depth and identify other components such as parenting, relationships and social interactions. These informed, and were integrated later, into the core category of this study.

3.4.2.3 The constant comparison of the data

The constant comparison of the various data episodes facilitates the theoretical understanding of the emerging categories (Bryman 2001). The researcher needs to be alert to similarities and differences, actively analysing the material. The extent of the comparison of which data is not defined (Glaser and Strauss 1967). While the method does not test categories, their properties or theory as such, it strengthens confidence in the findings by seeking out the range of different cases linked to the emerging hypothesis (Silverman 2001).

The data in the current study were compared within each and across all of the sets of respondents. For instance components of the category network 'causality' were initially identified during four couple interviews. Their understanding of the causes of the illness was integral to these respondents' experience of postnatal depression. When I compared their comments with other interview sets, I found, that all couples referred to this aspect of their experience in some way. A more detailed analysis of their responses then allowed me to populate this category network with the various subcategories, which informed the participants' understanding of the causality of the illness.

Four distinct stages of the constant comparative method are described (Glaser and Strauss 1967, pg 105- 113): comparing incidents applicable to each category, integrating categories and their properties, delimiting the theory and writing theory. Theory development is an inductive process, which progresses through incremental stages of abstraction until the analysis is deemed to be complete. Questions, such as when, why and under what

conditions do the emerging themes arise, facilitate this process (Ryan and Russell Bernard 2000). In addition Strauss in particular stresses the need to examine the data in the light of current knowledge to test emerging hypotheses. Thus grounded theory is characterised by both inductive as well as deductive elements (Haas 2003, Strauss 1987).

Strauss and Corbin's hypothetico deductive approach has been criticised for its implicit positivist perspective, which fits less with the aims of grounded theory (Rennie 1998). Subsequent work by (Blaikie 2000) explores these aspects further. He supports an abductive approach to analysis, which moves between theory, data generation and analysis to develop theoretical explanations through an iterative process of reasoning (see figure 3) (Miles and Huberman 1994).

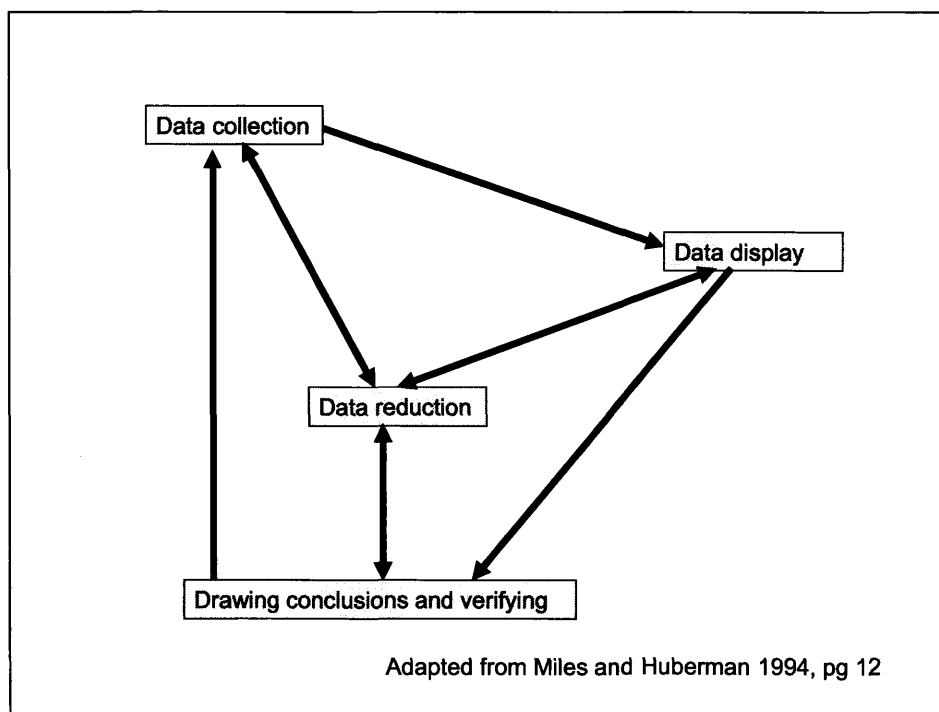


Figure 3 The iterative process of analysis

An abductive perspective reflects the practical application of grounded theory more accurately and aligns it with Strauss and Corbin's interpretation (Mason 2002). Glaser's comment that most researchers use grounded theory 'in part or whole' (Glaser 1999, pg 837) acknowledges the diverse interpretation of the method. My own approach to the analysis of the data utilised both inductive and deductive elements. For instance the second stage of the analysis tested hypotheses derived from the inductive, first stage of the analysis. These were developed further when I returned to the data and focussed specifically on the relationship- and support aspects of the responses. The third, inductive stage of the analysis then proposed a final core category and related processes (appendix 4).

Throughout this analytical process tension arises between three different types of knowledge: the concepts and questions guiding the research, the changing understanding of the subject as immersion deepens and the emerging differences to the original knowledge structure (Miles and Huberman 1994, pg 62). Such changes in understanding occurred in the current study and are described in the findings chapters. Concepts were proposed and categories adapted as the analysis progressed. In addition the concluding chapter of this thesis explains the links between the findings and explores them within the context of the wider theoretical frameworks underpinning the analysis.

It should be noted that the constant comparative method does not stand in isolation. It occurs simultaneously with other related analytical activities such

as questioning the data, writing memos and formulating hypotheses (Chamberlain 1999). It is questionable whether these are sufficient to provide credibility to a theory derived through a purely inductive approach. The emphasis placed by Strauss and Corbin on the deductive aspects of the analysis suggest a need to strengthen the robustness of the findings (Rennie 2000). While the evidence will support some hypotheses more than others, the need for a detailed examination and comparison of the data remains and is implicit in the method (Silverman 2000).

The discussion around the interplay between inductive and deductive elements of grounded theory and the diverse application of its tools can confuse rather than clarify the method. It is likely that each researcher utilises these according to their level of skill and the aims of the work (Strauss and Corbin 1997). It is expected that researchers using grounded theory will differ in the emphasis they place on various aspects of the method. This is evident in the current study, which followed Strauss and Corbin's (1997) approach. I applied the tools of grounded theory, but modified my approach to theoretical sampling. By reducing a large dataset into more manageable groups, I was able to cross check and develop my early findings. This adaptation of grounded theory allowed me to develop my understanding of the data and increased my confidence in the findings.

3.4.2.4 Saturation of the data

Integral to both sampling and coding is the concept of saturation of the data (Bryman 2001). The analysis ends when further examination would not add a

new perspective to the categories or concepts described (Schwandt 1997). Saturation has been reached when 'no new information seems to emergethat is, when no new properties, dimensions, conditions, actions/ interactions, or consequences are seen in the data' (Strauss and Corbin 1998, pg 136). In addition the researcher needs to make a pragmatic decision, when further sampling or analysis would reveal only limited new information or organisational constraints demand closure. Far from adding complexity to the decision making process, saturation can reduce the researcher's workload and support decision making (Glaser and Strauss 1967). It is important to guard against reaching too early a conclusion and to question the material carefully for sufficient width and depth. (Charmaz 2000).

The current study reached saturation after the first three sets of interviews with the first twelve couples. Interviewing continued with a further five couples as well as the return interviews after six months. This allowed me to gather additional detail to populate the category networks, check out the emerging hypotheses and review the data for any new concepts previously omitted. Further analysis continued as the data were revisited at various stages to gain further insights as my understanding of the material increased. The core category and its related processes were developed from the analysis of all datasets. I explored the data repeatedly and cross checked the various categories in detail before making my decision that saturation had been reached in the current study. No study can claim categorically that saturation has been achieved (Bluff 2005). A more realistic interpretation of

the significance of saturation recognises its limitations. Good data handling can facilitate saturation but does not protect against triviality or shallowness. At best, it signifies that the breadth of the material has been explored. Only a focussed approach, which presents a clear picture of the categories and processes proposed, can demonstrate depth (Richards 2005). The findings from the current study are described in three stages to reflect the developmental nature of the analysis and detail its various elements as they emerged.

3.4.3 Interpreting grounded theory

This study utilised the analytical strategies proposed by grounded theory such as coding, the constant comparison of the data and the use of narratives. In addition memos helped to chart the progress, my thoughts and feelings and the direction of the work. The analysis progressed through both inductive and deductive stages to abstract the data towards the development of the identified core category (Strauss and Corbin 1998). While these steps are in accordance with Strauss and Corbin's (1998) approach to grounded theory, they did raise a number of issues for me. While it is essential that the various steps of the enquiry are made explicit, it is recognised that they are often not linear, have to be revised and sometimes discarded (Miles and Huberman 2002). Grounded theory's aim to disassemble the data towards abstraction and the development of theory poses a further potential dilemma for the researcher. An awareness of the language used by the respondents and the inclusion of in vivo codes can facilitate this process. It can help to preserve the participants' meaning into further abstraction (Charmaz 2006).

Nevertheless, the need to remain close to the data can conflict with the goal to achieve abstract conceptualisation through sufficient distance from the data and make it messy and difficult to manage (ten Have 2004).

This was particularly noticeable to me during the analysis. I found it difficult, at times, to distinguish the boundary between induction and deduction. I used the various tools of grounded theory both in the inductive as well as the deductive phases of the project. Axial coding in particular was useful in both stage 1 and 2 of the analysis (appendix 4). It ensured that I compared concepts, checked out the early hypotheses and made new links. While I tried to stay close to the data, the process of coding had distanced and developed them into more abstract concepts. This posed the question: how far could I return to the data without compromising any abstraction, which I had already achieved? Ten Have (2004) highlights this tension. He suggests that grounded theory does have a potentially ambivalent attitude towards the data. It requires the researcher to fracture the data and develop abstract concepts. At the same time it stresses the need for the researcher to stay close to the data throughout the process of analysis. Although this may potentially place grounded theory more into the objectivist part of the spectrum of qualitative research (Charmaz 2000) this perspective has been questioned by others. Bryman (2008, 2001) in particular notes that the nature of Strauss and Corbin's work suggests that they were interested in their respondents' subjective experiences and how they utilised these interpretations in order to construct their social world. Their failure to explore the role of the researcher in the construction of this knowledge has

contributed to a sense of confusion as to the nature of the epistemology of grounded theory. Charmaz' (2006) more recent work positions grounded theory very clearly within a constructivist framework, which emphasises specifically the interpretivist nature of grounded theory.

I resolved this issue by identifying each stage of the analysis clearly and separating the inductive and deductive processes from each other. As I had a large number of data from more than 60 interviews, I decided to divide them into two sets for the purpose of analysis. Fig. 4 below illustrates the order of the four interviews with the couples and the individual partners. It demonstrates how the data were divided into two distinctive sets which were both separate and integrated with each other for the purpose of analysis. Set A, derived from the first three interviews with all participants, was used in the first inductive phase of the analysis and the subsequent testing of the hypotheses derived at that point. Set B, comprised all interview data, including those collated during the return interview after six months. It was used during the latter stages of the analysis to provide a further check on my emergent findings and to populate the core category and its linked processes. This allowed me to retain an overview of the material, use the second data set to check out the first and add confidence to my findings. I not only continued my coding from the first set to the second but also gained a new perspective on the second data set by developing the codes. I utilised those developed and reduced in the first two stages of the analysis to test them on a fresh data set for their applicability.

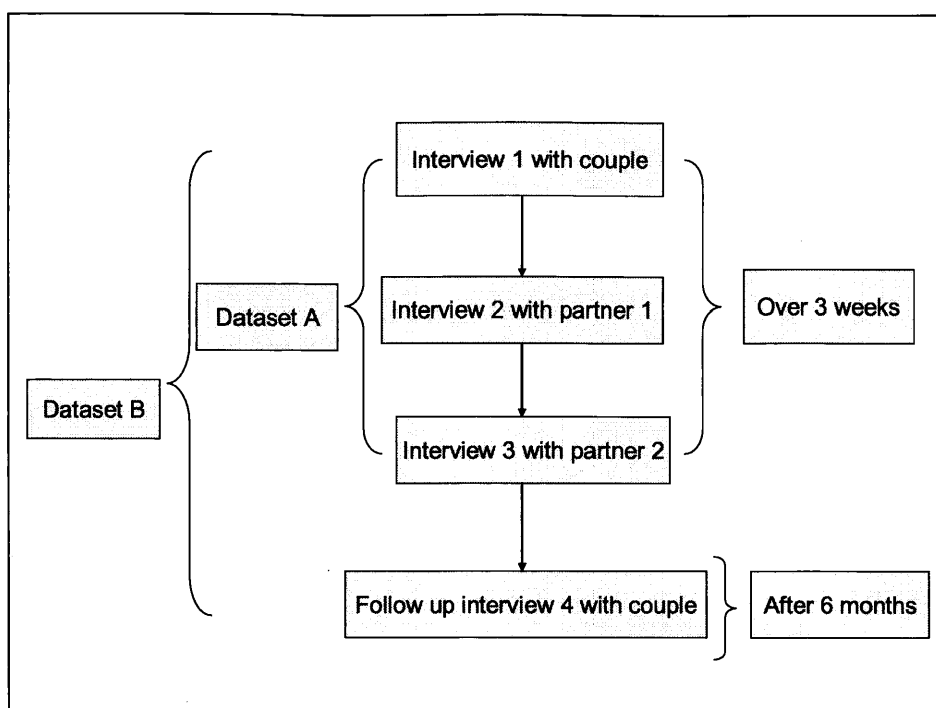


Figure 4 Order of interviews and related datasets

In this way the core category 'normality' was developed. Having emerged early as a theme, it was finally confirmed as a core concept during the third and final stage of the analysis. This strategy adapts both Glaser's (1967) and Strauss and Corbin's (1998) stipulation to treat all of the data as a coherent set. Separating the data into two distinct sets allowed me to use one set to confirm the findings from the other. Despite the decision to separate the data into these groups, I maintained continuity by constantly comparing the responses in both sets. This ensured that I retained an overview of the data and that material from all interviews contributed towards the development of the final theory.

This study lent itself to such an approach since the first three interviews were collected within a narrow timeframe of three weeks for each couple and thus

naturally linked together. In contrast, the return interviews occurred after a time lapse of six months and reflected natural changes in the couples' lives. As a result any categories developed from data set A, which could be confirmed by data set B, were more likely to represent issues of ongoing concern to the respondents. This approach reflects Strauss and Corbin (1998) use of additional data to 'densify categories in terms of their properties and dimensions' (Strauss and Corbin 1998, pg 201). Theoretical sampling used in this manner added further detail to the core category and its related processes. The strategy developed the concept of theoretical sampling by utilising the two datasets as a tool to cross-check and to add depth to the findings. It also reduced a large dataset into more manageable components, deepened the analysis and potentially enhanced the findings.

3.5 Thesis specific methodological issues

3.5.1 Sampling through stakeholders

Research ethics requirements stipulated that potentially vulnerable participants would be protected. Participants were therefore recruited by local health professionals, who knew and were working with this client group. They acted as gatekeepers to identify participants well enough to contribute to the study without endangering their mental health. The referring professionals had been working with those they referred, knew them well and were able to seek their initial consent. This ensured that vulnerable clients in their care were protected, but introduced a number of factors into the sampling process. One was the lapse of time between initial diagnosis and the

inclusion in the study discussed above. A further factor was the selection of participants likely to be less severely affected by postnatal depression. For instance the perceived level of illness was often cited as one of the reasons for non referral. In this way the health professionals controlled the selection process but also helped to ensure that potentially vulnerable clients were protected from harm.

A final factor related to the sample composition. All respondents were white, Scottish, with an average age of 32 to 33 years and from mainly managerial and associate professional backgrounds (see table 1 above). The composition of this sample reflected the predominance of white and partnered participants of middle to high socio economic status found in studies of postnatal depression (Ross et al. 2006). Three possible explanations for this phenomenon were proposed but could not be verified:

1. The participants' characteristics reflect the groups, with whom the recruiting professionals generally work and have most contact with.
2. The respondents were approached by the professionals because they reflected their own social attitudes, had had a positive working experience with them and were more likely to present the service in a positive light
3. The participants were judged to be those most likely to engage in the interviewing process and provide useful insights into their experience.

Sampling in qualitative research aims to reach respondents, who can offer a detailed and informed insight into their perspective. The gatekeepers' as well

as the researcher's primary responsibility is the protection of vulnerable clients. The composition of the current study's final sample reflected this inherent tension between the researcher's desire to access key informants and the need to meet ethical standards. The involvement of professional gatekeepers in the recruitment for this study contributed to the robustness of the selection process. The couples, who did agree to participate, were fully committed to the whole study. They talked about their experience in depth and provided a wealth of information for analysis.

3.5.2 Joint interviewing

Morris (2001b) explores the use of joint interviewing to examine the needs of cancer sufferers and their carers and explores a number of concerns, which initially led her to interview the participants individually. These were based on an expectation that the individuals in the partnership would have secrets from each other, which could not be shared during a joint interview. In addition the public accounts of each participant were likely to differ and required separate space to explore them. However these concerns were unfounded. When given the option, the participants chose to be interviewed together and presented a joint account of their experience. No significant power imbalance between the partners was evident. Instead, the participants created a joint discourse during the interview, filled in gaps in the narrative and presented their stories often from a 'we' perspective.

Morris' (2001b) experience reflects issues, which I considered in the design of the current study. Some similarities but also some differences were

apparent. My study also explored the perspectives of the two partners in a relationship and seeks out the couple's shared meaning. It anticipated some of her concerns and included both joint and individual interviews. How these were managed is of interest from the methodological perspective. I expected for instance that joint interviews would have the potential to highlight areas of conflict in the couple relationship. I was further concerned, that the presence of a more dominant partner would not allow me to explore the partners' different perspectives (Astedt-Kurki and Hopia 1999, Arskey 1996, Radley 1988). At the same time I felt it was important to speak to the couple jointly to understand their relationship and their experience of the woman's illness. My plan for the interviews with the couples made space for joint as well as individual sessions (see figure 4 above). The first interview took place with both partners present. It focussed on the experience of the illness and the couple's response to this challenge. Any issues raised during this first interview were then explored in more detail during the individual interviews with each partner. This allowed time for reflection after the first interview, provided space for each partner to present their own perspective and offered the opportunity to address any controversial issues, which might have arisen during the joint interview. The forth and final interview, which was conducted after an interval of six months, was again conducted jointly with both partners. The focus of this session was on any additional points, which the respondents felt needed to be raised. I was also able to check out early findings with the respondents and develop maps of their support networks. This interview was designed to allow the respondents to comment on the findings and the emerging theory.

The design of the study aimed to manage some of the potential conflicts of joint interviewing while providing space for individual perspectives to be explored. In addition Forbat and Henderson (2003) highlight a number of ethical considerations, which the researcher interviewing partners in a relationship needs to address. These relate to concerns about a potential conflict of interest between each partners and the researcher. The researcher may also attribute different importance to each partner's contribution or take sides. It is further possible that the research process itself intrudes into the couple relationship. This highlights the need to fully include each partner but also to ensure that neither feels obliged to participate.

Forbat and Henderson's (2003) concerns were addressed in the design of the current study. I gave the same information to both partners during the first joint interview, described its aims and answered any questions. This reduced the potential for a conflict of interest and included both partners from the beginning. I also reminded the respondents prior to each interview that their involvement was voluntary and could be rescinded at any time. A significant number of individuals declined their participation during recruitment for this study. At least one of the reasons cited suggested a different level of interest by the men (table 10).

Reasons for refusal	Participants approached
Male partner not interested	14
Relationship discontinued	5
Couple presently in crisis	4
Change of address	2
No reason	21
Total	46

Table 10 Reasons for non participation

The emphasis placed on joint recruitment resulted in an increased initial rate of refusal but facilitated inclusion and commitment in the long term.

Morris (2001b) further notes the desire of couples to be interviewed jointly rather than separately. I was able to identify any power imbalance in the relationship during the first couple interview. The subsequent individual interviews then provided the space to explore some themes in more detail, which had perhaps not been addressed in sufficient detail during the joint interview. The issues raised by both partners during the first interview subsequently influenced the following sessions (see appendix 3). This provided space for both partners to present their personal perspective further, if they wished. It ensured a balance of views (Arskey 1996) and reduced the potential for me, as the interviewer, to be expected to take sides. I stressed that anything discussed during the individual interviews would be confidential to reduce the risk of intrusion (Forbat and Henderson 2003) but suggested that the partners shared their thoughts with each other after I had left. It was clear that this did happen, since the participants often commented on the conversations they had had between interviews.

As the first three interviews were held at weekly intervals followed by the final joint interview after six months, the respondents had sufficient time for reflection and dialogue. This became apparent during the final interview, which focussed on the exploration of progress and the support networks described by the participants. The respondents had an opportunity to comment on the study's early findings and make suggestions for

improvements in professional services. This allowed the couples to feel included in the analytical process of the study and its recommendations. While Forbat and Henderson (2003) raise valid points for the researcher to consider, the current study offers one strategy to manage these concerns. Both participants were involved from the beginning and informed about each stage of the study. Combining joint and individual interviews facilitated the exploration of the dynamics in the couple relationship but also provided space for each partner to be heard as an individual.

3.5.3 Mapping the couples' support networks

To populate the support received and the activities provided by various helpers, I asked the couples to map their support networks (see figure 14 below). They listed the members of their network, those that had supported them and those on the periphery. The respondents named the helpers, described their relationship to them and identified the helping activity. A chart was compiled, which identified the relative position of each network member in relation to the partners. This allowed me to understand how close the couple perceived this individual to be to them in terms of the effectiveness of the support provided. During this part of the interview, the respondents were able to describe the support they had received and how they assessed its impact (see appendix 9 for examples of these support network maps).

The findings from this activity provided an insight into the respondents' understanding of their support networks as well as an opportunity to summarise my findings and check these out with the respondents.

3.5.4 Respondent validation

As part of the ongoing analysis, the emerging themes and categories were checked out with the respondents and explored further. Each interview informed the following contact with the participants. This helped me to clarify any issues, check out my tentative conclusions with the next respondent and adjust my thinking in the light of this response.

Triangulation has been proposed as a technique to ensure increased confidence in the findings of a study (Bryman 2001, Webb et al. 1966). Others are less convinced that triangulation can achieve this and focus more on the added information and depth, which different approaches to measurements can bring to the findings of a study (Greene et al. 1989). Richards (2005) stresses the need for the researcher to know, whether any explanations proposed by the study make sense to the participants. She points out that such an exercise is less important in terms of approval or disapproval but as an additional perspective, which needs to be integrated into the findings, adding further depth. Nevertheless data from different perspectives need to be included at the analysis stage of the study to achieve this full integration (Moran-Ellis et al. 2006)

This position is closest to that adopted for the current study. I used the return interview to the couples to gather additional data, enrich the earlier findings and expand on the issues identified during the first three interviews. I was particularly interested to check out my interpretation of the couples' support networks and the proposed processes. The participants mapped their

support network, commented on its members, their relationship to each helper and the helping activities. This allowed me to make adjustments to the networks and the processes proposed at that stage informed by the participants' comments on an early summary of my findings. Their remarks provided additional data to influence the ongoing analysis.

It should be noted that the use of respondent validation has limitations, which need to be recognised. It can clarify whether the findings make sense to the respondents (Ritchie and Lewis 2003), but does not guarantee their validity as such (Silverman 2000). Checking out the findings with the respondents in this study clarified issues and provided further data. However validation is sought through other means. These are embedded in the critical approach to the analysis of the data based on the constant comparative method, the comprehensive treatment of the data and deviant case analysis (Silverman 2000).

3.6 Conclusion

This chapter explored the methodological aspects of the current study. The researcher needs to be explicit about the philosophical perspectives and the values, which inform the work. The qualitative approach to enquiry aims to gain a deeper understanding of a phenomenon: the experience and support issues of couples living with postnatal depression. Grounded theory informed the approach to the analysis. Its tools were utilised to support the systematic exploration of the data generated from the interviews with the participants. As the enquiry evolves, the researchers needs to be able to be reflexive, learn

from mistakes and review the decision making process (Avis 2005). The findings should demonstrate the use of clearly identified procedures and relate to the wider social world. Examples from the current study illustrated the discussion of the tools used in the analysis of the data. Additional methodological considerations specific to this thesis were explored which related to the role of gatekeepers in sampling, the treatment of the data, issues of joint interviewing, the use of illustrative maps of the couples' support networks and respondent validation. This chapter summarised the methodological background of the current study and provided an insight into the theoretical considerations, which inform the work.

Chapter 4 Reflexivity

4.1 Introduction

The previous chapter explored a number of methodological considerations, which informed the approach to the management of the data and their analysis. The qualitative researcher is integral to this process and needs to be aware of the assumptions, which inform the various steps of the work. This knowledge can then 'bracketed' to minimise its impact on the research process (Ahern 1999). The nature of qualitative enquiry demands that the researcher contributes her understanding to the analysis and engage with the material to gain insights and identify new perspectives. Qualitative enquiry informed by social constructionism attempts to make sense of the social world of the participants by co- constructing meaning between the researcher and the respondents (Finlay 2002b). Symbolic interactionism further suggests that individuals gain self awareness in and through the interaction with others. Objectivity in qualitative enquiry is neither expected nor possible (Holstein and Gubrium 1995). However the researcher needs to be able to view her data and findings from the position of the informed research tool, aware of the theoretical, social and personal beliefs, which have influenced her propositions (Mauthner and Doucet 2003). I utilised Ahern's (1999) ten tips for reflexive bracketing to facilitate my reflection. These are set out here to ensure that they are highlighted prior to the subsequent presentation of the findings and clearly signpost personal assumptions, which informed this study.

Ten tips for reflexive bracketing	
1.	Identify some of the interests, which you might take for granted
2.	Clarify your personal value systems and acknowledge areas in which you know you are subjective
3.	Describe the areas of potential conflict
4.	Identify gatekeepers' interests
5.	Recognise feelings that could indicate a lack of neutrality
6.	Is anything new or surprising in your data collection?
7.	Are there any methodological problems that can be transformed into opportunities?
8.	Reflect on how you write up your account
9.	Consider whether the supporting evidence is supporting your analysis
10.	Are you consistently overlooking data concerning a different analytical conclusion?

Table 11 Ahern's (1999) ten tips for reflexive bracketing

Throughout the thesis I have highlighted my ontological and epistemological assumptions, which are informed by social constructionism and symbolic interactionism. The remainder of this chapter describes my own assumptions within the framework of Ahern's (1999) ten tips for reflexive bracketing outlined above.

4.2 Taken for granted interests

The researcher should identify various personal assumptions such as gender, race, socio-economic status, political milieu and possible power relationships, which have the potential to influence the outcome of the work. My own personal background as a woman and mother is relevant and needs to be acknowledged. I have raised my own children and balanced the demands of family and work. Motherhood for me represents a significant life event, which requires commitment and makes significant demands on the woman's personal life. These can impact on the couple relationship and

stress it to its limits. Only commitment from both partners can ensure that the relationship and the family unit remain intact.

While these views reflect some of my personal experiences, I observed similar stresses in the families, with whom I worked in my clinical role as a health visitor. Over a period of 10 years of professional practice, I encountered a large number of families, who seemed to report similar experiences. Accounts reported by a number of researchers informed by a feminist understanding of postnatal depression further supported these views (Lewis and Nicolson 1998, Mauthner 1999, Nicolson 1999, Oakley 1979). In addition postnatal depression is increasingly being recognised as an important challenge to maternal and family health (Scottish Intercollegiate Guidelines Network 2002, CPHVA 2001, Department of Health 2003, Scottish Executive 2003a, Scottish Executive 2004). My interests were both personal and professional. I wanted to understand how couples respond to the complex challenges of new parenthood and postnatal depression. I also wanted to be able to use this information to inform the delivery of clinical services for this client group

These two drivers for the study created the potential for tension in the relationships, which I sought to build with the study's participants. I was aware that I engaged in the interviews from two perspectives: as a woman and a professional. I had a personal interest but also sought information, which could be of interest to other workers in the field. Potential difficulties can arise from such a discrepancy in the interests of interviewer and

interviewees (Neill 2006). In this case, it is important that the researcher makes her values explicit rather than attempts to mask any apparent differences between researcher and participant. In this case honesty can facilitate the building of a relationship with the respondents and increase trust in the findings.

I became aware during the interviews, that the participants saw me less as a woman interested in the experience of other women and their families. Instead, they hoped that I, as a professional, would be able to influence service delivery. Some of the respondents in fact expressed this view as a reason for agreeing to participate in the study. This made me aware that I was in an unequal power position, where the participants in the study perceived me as being able to change practice. While particularly feminist researchers strongly reject such an unequal distribution of power (Mauthner and Doucet 1998), it could be argued that it also allowed the respondents to express their views of the services they had experienced to an interested professional. Accordingly the encounter provided the respondents with an opportunity to voice any concerns and represented a potential trade off for their engagement with the interview process.

In addition my role as researcher itself added a further dimension to this dilemma. I conducted in depth interviews, which were intended to allow the participants to explore those aspects of their experience most of interest to them. However I also had two areas of interest, which I wanted to explore. As I progressed through the interviews, the process of concurrent analysis

identified areas, which informed my questions and potentially limited choice for the participants. Johnson (2002) highlights the potential tension created by the two aims of the in depth interview: the exploration of the respondents' perspective and the verification of analytical conclusions. I sought to address both: I utilised my own questions as they developed from the progressive analysis but also consciously created space for the respondents to 'go where they wanted to go' (Johnson 2002, pg 113). This strategy was acceptable to the respondents. They utilised these openings to add further points, which they felt they had omitted during a previous contact. For me issues of personal experiences as a woman and mother, professional interests and concerns about power differentials were some of the interest, which I needed to be aware of.

4.3 *Personal value systems*

Ahern's (1999) second point relates to the personal value systems and areas of potential subjectivity, which may further influence the research process. For me, these were closely linked to the issues raised above: my view of parenthood as challenging work, which often has a greater impact on the women than the men. At the same time, I was aware that my professional work brought me into frequent contact with the women but much less with their male partners. This did not mean that they were excluded from the conversations in the women's homes. On the contrary, they were always present '*in absentia*' as an influence and a key factor in the women's lives. My reflection on my personal value systems and the perceived 'presence in absence' of the men triggered my research interest. What was the men's

perspective? How did they manage the challenges of parenthood and their partners' illness? I was visiting the women and some men in my professional capacity but how were the other men being supported?

In addition I was aware that my closer involvement with the women and my own gender were potentially more likely to make me focus on the women's perspective rather than that of the men. The challenges, which interviews with more than one participant in a relationship can present, have been explored by a number of authors (Morris 2001b, Arskey 1996, Forbat and Henderson 2003). These were earlier discussed in relation to this study. I made a conscious effort to reduce this potential bias. I ensured that both partners were always included in conversations and that each partner's views were sought. I also endeavoured to obtain a balanced input from both partners during the couple interviews and speak to the partners separately to hear their individual voices. As a consequence three personal considerations needed to be managed in the work. They related to my personal perspective on parenting work as more challenging for women than men. I was aware that I had more contact with the mothers during my professional work. However the fathers, even if they were absent from these encounters, were highly significant in the lives of the women I worked with.

4.4 Areas of potential conflict

The areas of potential conflict, which the researcher is encouraged to consider, regard the types of people and situations which might be the cause for anxiety, annoyance but also enjoyment. Any potential problems, which

might arise for the participants from the publication of any research results, should also be identified (Ahern 1999). For me two issues were of particular significance. These related to the potential conflict of my role as a clinician and researcher and my feelings about the level of engagement from some of the male participants.

As a clinician I had been used to engage with clients in a therapeutic, working relationship, providing a professional service. As a researcher, I was interviewing couples as an interested observer, trying to obtain their perspective on their experience and the support they felt was useful to them. I felt that it was important to make my professional background clear to the participants while stressing that I was interviewing them in my capacity as researcher. During some of the interviews it was apparent that the respondents expected me to offer a professional opinion on their experience or on the treatment they had received from various professionals. I deflected these requests and suggested that they checked out any questions with their professional contact. While this course of action did comply with ethical requirements and good interview practice (de Laine 2000, Dickey-Bloom and Crabtree 2006), I was aware of feelings of discomfort, a sense of letting people down, and failing in my professional responsibilities. This is an aspect of research, which has been highlighted by Finlay (2002a). She used introspective reflexivity to examine her role dilemma as an occupational therapist researching the life world of her professional colleagues. She felt compelled to become involved in the care of a patient during an observation in the clinical area. Only on reflection was she able to realise that this

reaction stemmed from her personal need to be involved and become an active participant. My personal feelings of discomfort may have arisen from similar needs. However, while the researcher needs to guard against the possibility that the research interview itself becomes a therapeutic encounter, this does not necessarily mean that participants can not benefit from participation. The research interview should not be seen to be a counselling intervention, but the opportunities it offers to reflect on experience can be therapeutic for research participants (Exley and Letherby 2001). Even in interviews to explore emotionally difficult issues such as bereavement or psychiatric illness (Hynson et al. 2006, Jorm et al. 2007), participation in an interview can be beneficial. Having the opportunity to present their illness narratives can help patients make sense of their experience by making it visible to caregivers and in particular to those with a medical perspective (Sakalys 2003). When participants suggest that the interview encounter acts as a therapeutic contact this should be seen against the wider background of clinical service provision, an opportunity for individuals to be listened to within a socially acceptable context (Hynson et al. 2006, Peel et al. 2006). It can help participants make sense of the experience (Hynson et al. 2006, Shamai 2003), check out clinical information previously received with a source perceived to be neutral (Haigh et al. 2005) and air concerns about the care received (Haigh et al. 2005, Peel et al. 2006). The social contact with the researcher becomes valued and can be interpreted in terms of friendship and an opportunity for reassurance that the participant is not alone in their experience (Crighton et al. 2002).

While altruism and a desire to help others in a similar situation are often cited as the main reason for participation (Crighton et al. 2002, Levkoff et al. 2000, Peel et al. 2006, Grinyer 2004), other more personal motives are also suggested. These include reciprocity and an expectation that the contact has beneficial effects for both participant and researcher (Crighton et al. 2002). This suggests that the potentially therapeutic elements of the research interview are valued by the participants but should be understood within their wider context: they are opportunities for participants to tell their story and make sense of their experience. Instead of negating and delineating the research interview from the clinical encounter, it might be more useful to recognise the beneficial effects of the contact and acknowledge that the power relationship between participant and researchers is less imbalanced than previously suggested (Haigh et al. 2005). Nevertheless it should be noted that those asked to reflect on their participation and reporting positive benefits from the encounter are likely to have overcome any potential distrust and fear of stigma and may not reflect the perceptions of individuals who have decided not to participate (Levkoff et al. 2000). The literature, which reports on the beneficial effects of interview participation, should be seen within this context. While it suggests that research participation is likely to be more therapeutic than previously indicated, studies need to continue to be ethically sensitive (de Laine 2000) and recognise the potentially negative impact on participants (Jorm et al. 2007) particularly when exploring emotionally painful memories (Dyregrov 2004). I needed to recognise these various perspectives and aim to achieve a balance between my role as professional and as interviewer.

In addition I was aware of the potential conflict between my loyalties to the respondents and my professional colleagues, when clinical services were being criticised. It is important to acknowledge the institutional and political context of the research and the constraints, which this might impose, (Mauthner and Doucet 2003, Bell and Newby 1977, Bell and Roberts 1984, Smith and Hodgkinson 2005). While it did cause some anxieties for me, I felt that my main responsibilities lay with the respondents. They had entered the interview process with the expectation that their perceptions and voices would be heard. My main role was to represent their views to the best of my abilities, even if this caused a potential conflict with my professional colleagues.

My other concerns were related to the varying levels of engagement, which I sensed from some of the men I interviewed. While all of the men made time and participated actively in the interviews, three men in particular appeared to be partially engaged with the research process. For instance one father very clearly stated at the outset of our individual interview that he only had thirty minutes for our session. Another father arranged to meet at his place of work and again specified the time, which he would be able to give to the interview. I respected the constraints placed on the contact by these men, but considered the possible reasons for their request. These ranged from simple time clashes to a possible assertion of power by these men over me as a female interviewer. My gender might have affected my interviews with these men, because agreeing to participate can be interpreted as a loss of control and a threat to their masculinity (Schwalbe and Wolkomir 2002). Allowing the

respondent to choose the time and place for the encounter can, among other strategies, help to return some of this control to the man. Most men commented that they found it easier to talk to a woman about their emotional journey through their partner's postnatal depression. They were comfortable with the interview process. When I analysed the various interviews, I was aware that the responses from some of the men might have been affected by their perception of me and a need to present a strong male role. The two issues, which caused some anxiety for me related to the potential conflict of loyalties for me as a clinician and a researcher and a perception that some men possibly did not engage fully with the study. As I became aware of these potential areas of concern, I tried to resolve them by making a clear decision about my loyalties and to analyse the interviews with a specific attention to potential gender conflicts.

4.5 Gatekeepers' interests

This point suggests that the researcher becomes attuned to the research setting and the gatekeepers' attitudes towards the study. Their favourable response can reduce anxiety in the researcher and facilitate neutrality in the field setting (Ahern 1999). The role which gatekeepers can potentially play in the recruitment of participants to research needs to be acknowledged and included in the planning for a study particularly of clients from vulnerable groups. Gatekeepers can be family members close to the patient (Jairath et al. 2005), local community leaders (Sixsmith et al. 2003) or health care professionals (Head and Faul 2007). They can influence access to medical services (Bushnell et al. 2005) or the research recruitment process. It is

important that gatekeepers are recognised and respected in the capacity as stakeholders with an interest in the client and the project. Their recommendations have the potential to add credibility to the study and increase participation. However they may also have conflicting personal interests which can lead to the exclusion of potentially valuable informants (Sixsmith et al. 2003).

The reasons, which gatekeepers cite as influences on their decisions to recommend or reject participation on behalf of a patient, include an assessment of the risk- benefit ration, the feasibility of the study and, in the case of family members, compatibility of the project with other family goals. In addition they consider the general appeal of the study and its aims. Gatekeepers perceive their role as protective of the patient and her care (Jairath et al. 2005). However, particularly family members can also act as surrogate gatekeepers by patients for whom this can provide a more acceptable reason to decline participation in a particular study (Jairath et al. 2005). The beliefs of gatekeepers have a significant impact on their referral patterns. For instance when a diagnosis potentially carries a perception of stigma with it, gatekeepers are less likely to refer to the research team. If they perceive the research to be important, they are more likely to refer (Levkoff et al. 2000).

The perceived need to protect vulnerable patients from harm through participation can significantly affect recruitment to a study. For instance researchers and care workers can have different perceptions of harm and

vulnerability (Head and Faul 2007). The worker's perception that participation could be emotionally and physically challenging can affect referral rates to a study. In extreme cases this perception can extend to a refusal to cooperate with the research team and a failure to complete research records (Head and Faul 2007). Such a response does highlight the strong emotions generated by the gatekeepers' desire to protect their clients from harm but also raises concerns about the rights of the patient to make an autonomous decision to participate. While it is important for research teams to involve gatekeepers, who are close to the potential participants and more likely to identify relevant individuals (Levkoff et al. 2000), their impact on recruitment needs to be acknowledged and included in the research planning process.

Two issues of concern for this study were the willingness of gatekeepers to become engaged with the study and the referral of potential respondents. The recruitment strategy for the study required that potential participants were approached initially through gatekeepers such as professionals and voluntary workers with an interest in the subject. Although medical colleagues and voluntary workers from local support organisations were keen to be involved, only nursing colleagues did eventually refer clients to the study. This referral pattern possibly reflected the focus of the work of these professionals. For instance medical colleagues reported that they generally referred any patients diagnosed with postnatal depression to the health visitor working for follow up visits. Workers from the non statutory agencies had mainly contact with single mothers or mothers in stressed relationships.

As a result nursing staff working in primary care were the main referrers for this study.

The selection of participants and the characteristics of the final sample for the study need to be considered. The average age and socio economic characteristics of the sample for instance reflects that of many other studies in postnatal depression, which focus on white and often middle class families (Ross et al. 2006). Although recruitment caused some concerns at the beginning of the project, those respondents, who did join the study, were committed and keenly engaged at all stages of the research. The possible interests of the gatekeepers need to be acknowledged. Their impact on the composition of the sample did not present as much of an issue for me as anticipated. On the contrary, I am grateful to my colleagues for their support and interest in the project.

4.6 Potential lack of neutrality

Ahern (1999) stresses that the researcher should clearly identify any feelings and situations, which generate a negative, positive or guilty reaction. He suggests that these could indicate unresolved conflicts from the researcher's own background, which might impact on the current project. For me, this point highlighted a number of issues. I was conscious of my position as a woman interviewing men. I was also aware of the potential of the interviews to breach the barrier between interview and therapeutic exchange. Finally I could be caught up in the couples' personal stories and lose my analytical perspective.

The potential gender conflict between the female interviewer and the male interviewee has been highlighted by Warren and Hackney (2000) and Arendell (1997). The request of two men to impose time limits on our encounter did cause me some concern and reflects the experience of other female interviewers (Warren 2002). However it should not detract from the very positive responses of the other men and their full engagement with all aspects of the study.

My greater concern was the need to ensure that the interview would not be used as a therapeutic encounter (Kvale 1996). Nevertheless, it should be recognised that the interviewer and interviewee construct meaning together during the interview. The new perspectives created in this exchange have therapeutic potential (Hall and Callery 2001). Women in particular can find this empowering (Reinhartz and Chase 2002) but need to receive appropriate support from the interviewer when challenging issues arise. I addressed these concerns by encouraging the respondents to discuss any detailed questions related to their clinical care with their clinician. In addition I shared my findings from other interviews with the participants and sought their comments. This strategy addressed issues of reciprocity and nurtured my relationship with the participants (Legard et al. 2003). It also acknowledged professional boundaries and ethical concerns.

Finally, I was aware that my repeated visits to the couples brought me into close contact with them and their personal stories. Since it is not possible for the researcher to be completely objective, it is important to engage with the

research process and its context to understand the key issues (Koch 1994, Sandelowski 1986). However the researcher needs to be aware of the problems, which this subjectivity and involvement can potentially generate. Such awareness then becomes an integral part of the process of reflexivity (Lincoln and Guba 1985). I was conscious that my personal engagement with the couples could affect my management of the information they shared with me. I attempted to maintain a good relationship with the participants, while reflecting on the context and issues of the encounter.

Reflection on the issues of neutrality raised three important concerns for me. I became aware of my ambiguous feelings towards some of the respondents, which could have affected my reaction to them and influenced my analysis of the data generated from their interviews. Throughout the study, I was also conscious that I needed to delineate the interview from a therapeutic encounter. I had to retain an analytical distance to the personal stories of the couples while maintaining a positive relationship with the participants. This allowed me to obtain rich data from the various interviews but also retain an overview of the commonalities and differences in the responses.

4.7 New or surprising elements

Any study seeks to find new or surprising information in the data, which have been collected. However the absence of surprises could be an indication of boredom in the researcher or desensitisation to the data. One of the difficulties in qualitative research is the decision when saturation of the data has been achieved. The researcher should ask whether the absence of

anything new is an indication of analytical block or saturation (Ahern 1999). I was able to share my early findings with peers at various conferences and research groups. This allowed me to discuss my ideas and informed my decision making. Saturation was reached after the first three sets of interviews with twelve couples. I continued to interview a further five couples thereafter and returned to all participants after six months. This allowed me to check my early findings, consolidate the emerging hypotheses and ensure that saturation of the categories defined during the earlier stages of the analysis had been achieved. As other qualitative researchers suggest, part of the decision to end the process of analysis needs to be pragmatic and based as much on the occurrence of no further, new data as well as time and resource constraints (Bluff 2005). At the same time, I was aware of Richards' (2005) warning not to force saturation because of looming deadlines. The decision that saturation had been achieved was reached mainly through the careful constant comparison of the data at various stages of the analysis but also the pragmatic need to bring the study to a conclusion. For that reason I am aware that some aspects of the data would benefit from further exploration after the conclusion of the current study. Recommendations for future research are made in the concluding chapter 8.

4.8 Methodological problems or opportunities

The task of qualitative research can lead to dead ends and blocks in the process of analysis. Ahern (1999) recognises this difficulty and suggests that the problem is reframed to address potential obstructions. It might be possible to ask another group of respondents or consult other data sources

to gain a different perspective on the problem. While I did not reach an impasse in the research process itself, I did need to seek out a different perspective when I tried to link the themes emerging during the first stage of the analysis with later, more abstract concepts. I resolved this problem by returning and linking these components differently and reviewing the emphasis I had placed on each of them. Some early codes were moved during this process to become categories, while others were reduced to subcategories. The core category 'normality' emerged from this process of review and change in emphasis. These steps are described in the findings chapters of this study (chapters 5 to 7). Hence a potential block in the research process was turned into an opportunity and helped me move the analysis forward towards the identification of the core category.

4.9 The write up

This point highlights the need for the researcher to remain reflexive during the writing up stage of the project: what is reported and how this is presented. The researcher needs to ensure that she quotes all respondents equally and does not favour some participants over others. Articulate respondents can make the process of analysis easier for the researcher and introduce bias into the findings (Ahern 1999). In addition the choice of personal pronoun used in the report can reflect the researcher's underlying epistemological stance, for instance an assumption of objectivity. My reflection on these two issues led me to check my choice of quotation from the various participants and review my style of writing. I became aware that I needed to ensure that the voices of both partners in the couple relationship

were heard equally. I also checked that I had used a range of respondents as I wrote up the findings for this thesis.

I chose to present the work using a mixed approach to the presentation, using the first and third personal pronoun throughout the work. I was aware that I needed to meet academic conventions and make the work more accessible to readers with potentially positivist leanings such as policy makers and clinicians (Finlay 2002a). This contrasted with my desire to illustrate my personal perspective and how this had influenced my analytical decisions. I chose my strategy to reconcile the inherent tension between a research community often more familiar with a positivist approach and the need to highlight the influence of my personal assumptions on the research process. Reflection helped me to present a variety of respondent voices and meet the diverse expectations of the research community.

4.10 Support for the analysis

The two final points relate to the analytical decision making process and the need for the researcher to be sensitive to alternative interpretations. The links between the findings and the relevant subject literature need to be guided by the data and not the personal, cultural assumptions of the researcher. In addition it is important to remain open to the possibility of a different analytical conclusion (Ahern 1999).

These two points proved the most difficult to address since they challenged my analysis and the interpretation of my findings. The literature supporting

my analysis was drawn from a range of disciplines and reflected the range of issues identified by the respondents. Did my findings suggest a 'blind spot', which had led me to ignore important alternative explanations? I was aware that I approached the study from a personal perspective, which sees parenting as a family responsibility and a task for both parents. This had led me to expect that postnatal depression would impact on both partners, affecting them practically and emotionally. The respondents in this study differentiated between individual and couple tasks during the illness process. The illness challenged each of them as individuals but also raised issues of common concern. For instance a strong sense of commitment to the relationship improved the outcome for the couple. The findings reflected some of my assumptions but also questioned them in terms of the extent to which each partner was affected by the illness.

This is an aspect of the work, which is likely to benefit from distancing and a return at a later date. The doctoral researcher can often find it difficult to admit to confusion and tensions in their work due to the various insecurities inherent in the process (Mauthner and Doucet 2003). Time and distance from the immediacy of this context can develop awareness of some of the more complex assumptions, which informed the initial approach to the analysis and interpretation of the findings. Reflection on the potential influence, which my personal assumptions had on the outcome of my study, has allowed me to identify them more clearly and 'bracket' them whenever possible. This is an aspect of the work which would benefit from further exploration and distance from the immediacy of the current process.

4.11 Conclusion

This chapter considers the various influences, which inform this study. The qualitative researcher needs to demonstrate that the respondents' experiences rather than the researcher's personal views are presented. Only when personal assumptions are acknowledged, can they be excluded or 'bracketed' to construct knowledge independent of a personal perspective (Ahern 1999). Reflexivity allows the researcher to identify the various assumptions, which influence the research process and acknowledge the context, in which the work is positioned. Personal experiences are not excluded but examined to understand their impact on the work. Ahern's (1999) ten tips for bracketing facilitated this process for me. It allowed me to devise strategies to address the issues thus identified. At the same time, I recognise that subjective awareness is important for the qualitative researcher and can sensitise her to common themes and differences. Some assumptions and their influence were more easily identifiable; others are likely to benefit from future re-examination.

Chapter 5 Findings stage 1: Seven early themes

5.1 Introduction

The findings from this study are presented in three stages to reflect the developmental nature of the analysis, evolving from early open coding and the tentative allocation of themes to the proposal of the final core category and its related processes. Each of the following three chapters is devoted to one distinct aspect of the analysis moving between induction and deduction as the work progresses. In this chapter the early stages of the analysis are described. They involved the allocation of codes to the data, their grouping into thematic concepts and the development of category and subcategory networks. The networks were used to formulate working hypotheses to test the relationships between the various categories through axial coding. The hypotheses are presented in the first instance as explanatory statements for the networks and represent the first inductive stage of the analysis.

The study focuses on postnatal depression and its effect on the couple relationship. As a professional, I was further interested to explore the support needs of the couples with the aim to identify issues of relevance for clinical practice. These areas of interest informed the open coding and hypothesis development. The analysis as a whole reflects the dual strands of enquiry, which led to the development of the core category and associated processes proposed by this thesis.

The chapter closes with the narratives of the key issues identified from the perspective of the woman, her partner and the couple. It provides a summary of the core concepts and the key categories, which informed the next analytical steps.

5.2 Respondents' voices

When analysing data from interviews two specific issues need to be considered. These relate to the role of the narrative and the extent, to which credence to the accounts should be given, in particular whether interview data provide privileged access to the personal experience of the participants. It needs to be clear how these accounts are to be read and what the purpose of personal narratives is from the perspective of the respondent and the researcher.

Interview data can be treated as either truthful accounts of the personal experience of the respondent or as a reflection of the realities which underlie the experience. Narrative accounts need to be recognised within the context of the participants' social and cultural world and as such can be said to reflect a particular perspective and moral context (Silverman 2001). Although often cited as a means to access privileged insights into the personal experience of the participants, narratives are only one form of representation. They need to be subjected to contextual analysis rather than treated as a simplistic, subjective account (Atkinson 1997). Since personal accounts are created through a complex process of interaction and interpretation, which is situated within the wider social context of people's lives, these factors need to be

acknowledged as part of the critical analysis of the data (Atkinson and Silverman 1997).

One of these contextual factors is the consideration of the purpose of the narrative accounts, whether the account reflects the 'real life' of the participant or is an imaginative reconstruction for the purpose of the research (Clandinin and Connelly 1998). While the data from the research interview can facilitate the exploration of the subjective world of the respondent, they should not be treated at face value (Wengraf 2001). It is likely that individuals exclude aspects of their experience which are contrary to the picture they want to present (Riessman 2002). Stories have alternatives, which are implicit and embedded in their wider social context (Riessman 2002). Respondents use the opportunity to narrate their personal accounts to restore order at stressful points in their lives and to demonstrate competence through checks on acceptable reasons. It is suggested that narratives created within the research interview can not be treated as literal descriptions but should be judged as attempts to present legitimate accounts for a specific setting (Dingwall 1997). In this context, telling the story to particular individuals contributes to the process of self representation and provides an opportunity to summarise the personal experience (Riessman 2002). In some instances the narrative can have therapeutic benefits for the participants since it can help to restore a sense of continuity for the individual and make the experience visible to the care giver and the medical world. By listening for meaning rather than facts the interview can provide a different perspective and an opportunity for the patient to be heard (Sakalys 2003).

Atkinson (1997) warns that these personal narratives must not be seen to give privileged access to the voice of the participant. As memory itself is uncertain, personal accounts reflect the current rather than the past voice of the respondents (Clandinin and Connelly 1998). Narratives are shaped in the process of interpretation and represent not only the voices of the respondents but those of all involved in the research process (Riessman 2002). This perspective emphasises the need to recognise the multi layered nature of the accounts. Although no account will fully reflect the complexity of the interaction, it is the role of the researcher to present them in a manner which can help to make a positive difference to those involved in the research process (Warr 2004).

Data in this context should not be seen as representing an absolute truth, which is open to proof or self evident, but shaped by the listener's own social world (Riessman 2002). They do not necessarily provide privileged access to private accounts (Coffey and Atkinson 1996a) but can become the means to gain insight into the participant's world beyond the story (Melia 1997). In this way the researcher can gain access to the more complex set of ideas beyond those presented at face value and transform the sense of the data into plausible stories (Melia 1997). To aid this process of transformation the researcher needs to question the text by asking: does it represent an individual understanding or a broad interpretation? What is the expressed or intended meaning? What aspects are represented and what is the context (Kvale 1996)? Interview data can not necessarily be treated as true accounts. Because they are autobiographical (Atkinson 1997), they have the potential

to provide insight into the respondent's social context (Kvale 1996). As such, even inaccurate accounts should not be dismissed since they can contribute to real outcomes in the life of the respondent (Kvale 1996). As the researcher seeks to investigate a phenomenon, direct access to it is not possible since it is embedded in various cultural assumptions (Altheide and Johnson 1998).

Bochner (2001) questions whether it is legitimate for the researcher to question the truth value of individual accounts. If people's stories are their attempt to make sense of the world, then their narratives never represent an absolute truth of personal experience but reflect their attempts to uncover a pragmatic truth. By elevating the cultural context above the individual story, as Atkinson (1997) suggests, the researcher is in danger of adopting a positivist perspective, which presumes that the analyst is able to access higher levels of interpretation than the speaker (Bochner 2001). An attempt to authenticate the stories suggests that the researcher has to make a judgement in terms of which stories can be judged to be more privileged than others or which can be assessed as being more 'true'. Bochner (2001) contends that stories of illness do serve a legitimate purpose in themselves. They allow the person to gain therapeutic benefits, help to legitimise the experience and, in the process, overcome the silence of suffering by making it visible to the accessible world. Rather than question the authenticity of these stories, it is the responsibility of the social sciences to engage with them (Bochner 2001).

It could be argued that the two perspectives are not necessarily exclusive. Their differences highlight the inherent conflict faced by the qualitative researcher who tries to acknowledge the voice of the individual narrator but also recognises that this voice is positioned within the wider social context of the person, their life experience and the research interview. Data can be interpreted from a number of perspectives: the subjective world of the informant, the interview as interaction and the discourse emerging through the interview (Wengraf 2001). In the current study I recognise these factor but also the need to remain close to the respondents' personal narratives in an attempt to allow their voices to be heard by the professional healthcare community. Their statements have been treated as those of informants and witnesses to their experience but also as representative of others in a similar situation (Kvale 1996). At the same time, I recognise that respondents are not necessarily aware of the range of contextual constraints on their actions and that the research process itself involves interpretation at a number of levels (Riessman 2002). Attention has been paid to the use of language in the participants' statements. Suggestions for their interpretation are offered.

5.3 The identification of category networks

The allocation of codes to the data was the first step in the analysis. Codes were informed by the literature on postnatal depression, professional terminology and generated from participants responses (see table 11 below). They were subsequently arranged into thematic groups, combining Rennie's (1999) units of meaning approach and a grounded theory methodology. This allowed me to organise the large number of codes generated in the first

examination of the early couple and individual interviews (see tables 4 and 5 in the methodology chapter). The groups also facilitated the concurrent interview process and category development (see appendix 5)

Informed by literature	Informed by professional terminology	Informed by respondents
Relationships	Psychosocial issues	Need for information
Gender issues	Treatment	Coping
Attitudes		Sources of support
Types of support		Baby/ childcare related issues
Roles		Other
Illness process		

Table 12 Terminology utilised for code generation

Subsequent examination of these early groups resulted in their revision and the addition of further codes. Seven categories with linked subcategory networks are proposed as a result of this process: causality, emotional health, access factors, roles and gender, professionals, solutions and help seeking. Each category contains subcategories, which are populated by various codes. For instance the first category 'causality' has three subcategories: external factors, internal factors and responsibility. Each is populated by a number of related codes. For instance the subcategory 'external factors' has the following codes attached to it: physical factors, prenatal factors and baby factors. The networks described below illustrate the inductive process from the early text codes to the development of categories and their related subcategories. At this stage, the links proposed were tentative and acted as the basis for early hypothesis development. A mind map of each of the seven categories illustrates these at the beginning of each section describing the various categories. For each category the

related subcategories are mapped together with their various codes (appendix 6 for a summary overview of all maps).

Mapping the categories in this way helped to examine and formulate links between the various subcategories and their related codes. It informed the later stages of the analysis and the development of more abstract concepts. The various categories included in the networks overlap at times, with some subcategories and codes arising in more than one network. This reflects the complex nature of the phenomenon and the exploratory nature of this phase of the analysis, seeking tentative connections and interpretations. Tables indicating the patterning of responses in the networks are presented in the different category sections in this and the following chapter. The quotes cited illustrate the range of perspectives presented by the respondents during the various interviews with the couples and individual partners. They are examples of the continuum of views expressed by the participants. The names of the respondents have been changed to protect their anonymity (see appendix 2 for a short profile of each couple). The quotes are identified by the name of the respondent, the interview during which the comment was made and some short biographical details to provide additional contextual information to (see figure 4 for order of interviews). In addition, the reader is reminded of the couple summaries listed in appendix two, which provide further contextual information about the respondents' personal background.

The various subcategories described here are multidimensional. For instance the cultural factors, which influence the couples' decision making in the

network 'help seeking', can facilitate or block the process. The individual code names reflect the early exploratory nature of the enquiry at this stage of the analysis. They were easily accessible and allowed me to focus the enquiry on the key issues raised by the respondents. As the dimensions of the categories were developed, the subcategories were refined further.

5.3.1 Causality

This network illustrates the three subcategories, which represent the respondents' perception of the causes of postnatal depression. The couples consider a number of external factors and internal factors. In addition they place the responsibility for the illness on either the woman or the couple.

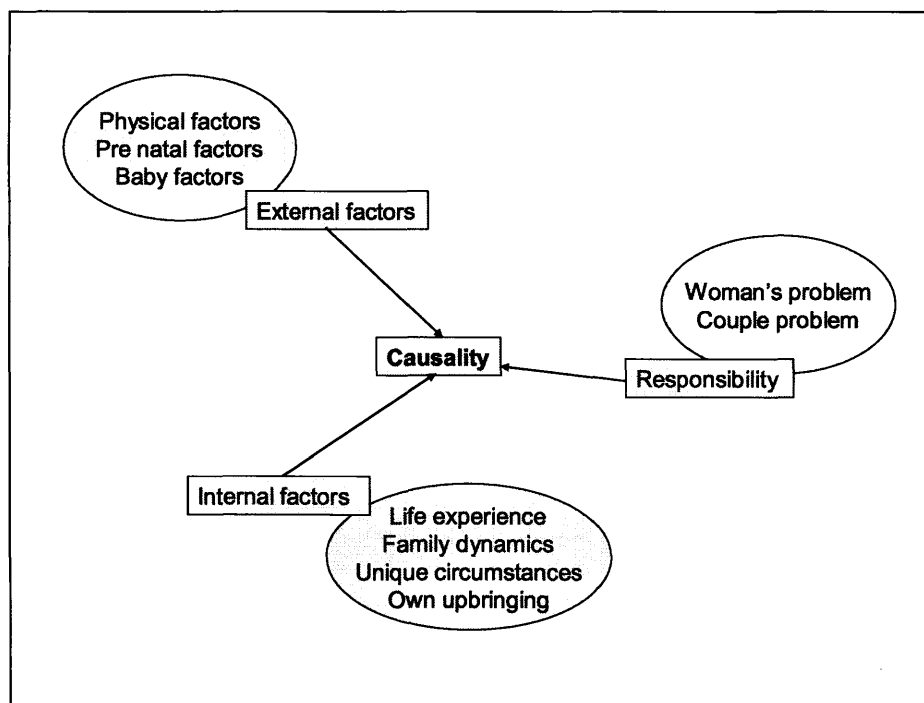


Figure 5 Network: causality

5.3.1.1 External factors

The first subcategory (external factors) in this network interprets the cause of the illness as external to the couple, placing its development outwith their control. Prenatal illness, physical illness as a result of traumatic birth events or the behaviour of a fractious baby are given as examples of such external factors. For instance Carla and Chris' baby was born following a difficult surgical delivery. They felt that this affected the infant's temperament and made her more challenging to manage. Carla felt that her postnatal depression was the direct result of these dual demands and outwith her direct control.

Carla, aged 29, living in a rural area, interview 1
baby was difficult with a LUSCS

While Carla and Chris saw the baby as the main cause of her difficulties, Hannah cited hormonal changes. Women perceived to be subject to hormonal influences, which affect her ability to manage the challenges of early parenthood. Freddy expanded on this view further by suggesting that postnatal hormonal changes in themselves could cause mental health problems.

Freddy, interview 1
No, no they were putting it down to hormonal changes, which your hormones go mental.

Other physical factors are also outwith the couple's control, but recognised as part of the expected challenges of new parenthood. Bert initially felt that two young children placed extra demands on Barbara's physical and

emotional resources. Both Bert and David attributed their partners' depression to the effects of sleepless nights and a new baby.

Dana, aged 35, living in a rural area, interview 1
I think we both thought it was just tiredness.

The respondents used a number of external explanations to make sense of the difficulties they experience. In the early stages following the birth of the baby, reasons such as a complicated delivery, a fractious child, hormonal changes and the additional workload generated by a new baby helped provide the respondents with a context for their difficulties. This interpretation contributed to their understanding of the causality of the illness as beyond their immediate control. While some couple favoured this explanation, others attributed their problems to factors more immediate to their family situation.

5.3.1.2 Internal factors

The second subcategory (internal factors) provides this contrast by suggesting that the illness is caused by factors internal to the woman herself or unique to the couple's own life experience. The couple's interpersonal dynamics, their relationship with their extended family and other unique personal circumstances are cited as explanations for the illness.

Dana and David's interpretation identified a range of factors specific to them as individuals and their couple relationship. Work commitments for instance affected their relationship and their response to their child's arrival. Dana felt that she let her partner down. She had high expectations of David but felt that she had failed as a new mother. David, in turn, cited his heavy work and

study commitments as the cause for not giving enough of his time to his new family. Both had underestimated the challenges of the new baby in both physical and emotional terms. David used the past tense and speculative conjunctive as part of his retrospective assessment of his own actions. His comment included both a description of his actions and a reflective consideration of possible other alternatives available to him at the time.

Dana, aged 35 and David, aged 36, often working away from home, interview 1
David: a new baby, I was trying to do Open University, I was doing other things as well. Far too much and, ehm, obviously I didn't give the time, that I should have done to our new family.

Dana: I don't think any of us realised, how hard it was going to be,

Specific personal factors were particularly important to Carla. She had failed as a mother and disappointed her partner and members of her family. This young woman was the youngest of all the respondents. Her feelings were shared by most of the other women (see table 16 'good mother' below). The couple had recently returned to live near her family after a difficult time with her boyfriend's family. She felt disappointed that she had not bonded immediately with her new baby and had found the adjustment to parenthood in a strange environment away from her family very difficult. This also affected her ability to share her feelings with those closest to her and had implications for help seeking from her partner and her family. Carla's response reflected both her feelings and her internal dialogue. She used the form of direct speech to create a sense of the immediacy in the interview and to illustrate the strength of her feelings.

Carla aged 29, four months since diagnosis, interview 2

I didn't want him to be disappointed in me and that's what I felt like – everybody would be disappointed – they'd feel like I'd let them down. So the whole, like the emotional bond/barrier thing there, I found really, really bad. "How can I approach this? How can I tell them? What am I going to say? They're going to think I'm pathetic"

The comments above illustrate the range of explanations proposed by the respondents in an effort to make sense of their experience and find a cause for their problems. They suggest that their own expectations of parenthood, a possibly unrealistic assessment of the challenges of caring for a new baby and their desire to fulfil the expectations of other family members affected their emotional health. Most of the couples cite a combination of both external as well as internal factors as contributory to her illness.

5.3.1.3 Responsibility

The third sub category (responsibility) relates to the perceived locus of control for the illness. The couples adopt two distinct perspectives: one group perceives postnatal depression to be the woman's responsibility. The other group understands the illness as a joint concern for both partners, who share the responsibility for its management.

When the illness is perceived to be the woman's sole responsibility, her partner is likely to misjudge the severity of his partner's difficulties. Bert for instance expressed his surprise during the joint couple interview that he had been unaware of the extent of his wife's problems. Barbara had experienced suicidal feelings but had not been able to share these with him. His comments on perceived male attitudes to a 'woman's illness' summarised not

only his own attitudes at the time but also that of other men. Bert's choice of phrase reflected his perception that his experience was not unique. This helped him justify his perceived inability to assess the severity of Barbara's illness accurately both to himself and the listener.

Bert, aged 32, joiner, interview 3

keep on going back to this impression I got that she wasn't as bad as she was, that must happen a lot as well, men that are not realising how bad the partners are. Us men, we are kind of, a man thing, that is just a woman's problem, she'll get over it

This attitude is not restricted to the men but also expressed by some of the women. They themselves often did not share their feelings with their partners but felt that emotional problems in particular were best managed outwith the couple relationship. Aileen and Alan frequently returned to this theme during their various interviews. Aileen felt she had not shared her feelings with Alan sufficiently. While Alan was supportive, Aileen felt that he was more comfortable with practical tasks in the home than with emotional issues.

Aileen, aged 30, second child, interview 1

he didn't understand because he wasn't to know because I didn't tell him..... but I just thought if I had said it in a different way to him you know he would have been more understanding rather thanjust coming outwith I can't cope you know and he was like: what are you talking about?

Managing Aileen's illness separately was not beneficial for the couple and created a sense of distance between the partners which they recognised in retrospect. Bert's comments on this issue reflect the other end of the spectrum of views. He felt a joint responsibility to address the issues raised for the couple by Barbara's illness. His attitudes are based on his sense of fairness and commitment to the couple relationship. A joint effort to resolve the difficulties was more likely to lead to improvements in her health.

Bert aged 32, 17 months since diagnosis of partner's illness, interview 1
I couldne seen myself saying: 'right deal with it yourself.' That wouldne have been fair ..., to leave her like that. And I felt well, two is bigger than one. So I felt, I had to help her whatever I could to get her to the other end of the tunnel.

How the respondents understand the causality of the illness is important, since it affects the partner's response to the woman's illness. In particular external explanations of causality help the couple accept their difficulties. It also raises the possibility that an illness caused by factors beyond the woman's control absolves her from guilt and allows her access to more sympathetic support from her partner. If external factors are perceived to have caused the illness, then the woman is more likely to be able to request help from her partner and family.

Attributing the causality of the illness to either external or internal factors, affects the couples' understanding and their response. The couples place the responsibility for the illness with either the woman or both partners. This affects their management and subsequent recovery. Table 12 below illustrates the patterning of responses in this network for each subcategory by age and social class of the respondents. Responses are distributed across both age and social background. All couples considered external causes to be part of the reason for their difficulties. Most also attributed the woman's illness to internal factors such as an inability to bond with the baby or share their feelings with each other. Six couples focussed on the external causes of her illness and did not consider personal issues to be of relevance. Most couples considered whether the responsibility for the management of the illness lay solely with the woman or with both partners, although for some

couples this was not a concern. Since all commented specifically on the external causes of postnatal depression, this concern might indicate that an external attribution was perceived to be seen as socially more acceptable by the respondents. There did not appear to be a link between the causal attribution of the illness and considerations of responsibility for the management of the couple's difficulties. For at least six couples, this was not raised as a concern. This could suggest that these couples were either more comfortable with each other or had not questioned this aspect of their relationship.

Couple	Age of partners	Occupational classification	External factors	Internal factors	Responsibility
Aileen/Alan	35/30	2	*	0	*
Barbara/ Bert	32/30	5	*	0	*
Carla/ Chris	27/29	3	*	*	*
Dana/ David	36/35	3	*	*	0
Evelyn/ Edward	35/36	3	*	*	*
Frances/Freddy	42/41	3	*	*	0
Gina/ George	28/32	3	*	*	0
Hannah/Harold	31/26	3	*	*	*
Irene/ Ian	28/26	3	*	0	*
Jane/Jason	24/18	unemployed	*	*	*
Karen/Kurt	31/30	5	*	*	0
Lena/Len	34/41	1	*	0	*
Maureen/Mike	30/24	7	*	*	*
Nancy/Norman	30/29	1	*	*	*
Olive/Oscar	34/35	5	*	0	0
Pam/Paul	38/37	2	*	0	0
Rachel/Richard	40/39	1	*	*	*

Table 13 Patterning of responses for network: causality

* indicates that this issue was raised by the partners during at least one of the interviews

0 indicates that this issue was not discussed by the respondents during the interviews

5.3.2 Emotional health

This network explains the range of emotional issues, which arise from the couples' experience of postnatal depression. It also illustrates the different responses of the partners to the illness and their reaction to the emotional demands made upon them. Four subcategories are identified. These describe the influences on the partners' and the couples' emotional health, their response to the challenge of the illness, the relevance of the partners' personal background and the maintenance strategies utilised to sustain the relationship. This category network links to the later network 'roles and gender'. Particularly the subcategories 'influences' and 'background' are affected by the respondents' perception of their role as individuals and parents.

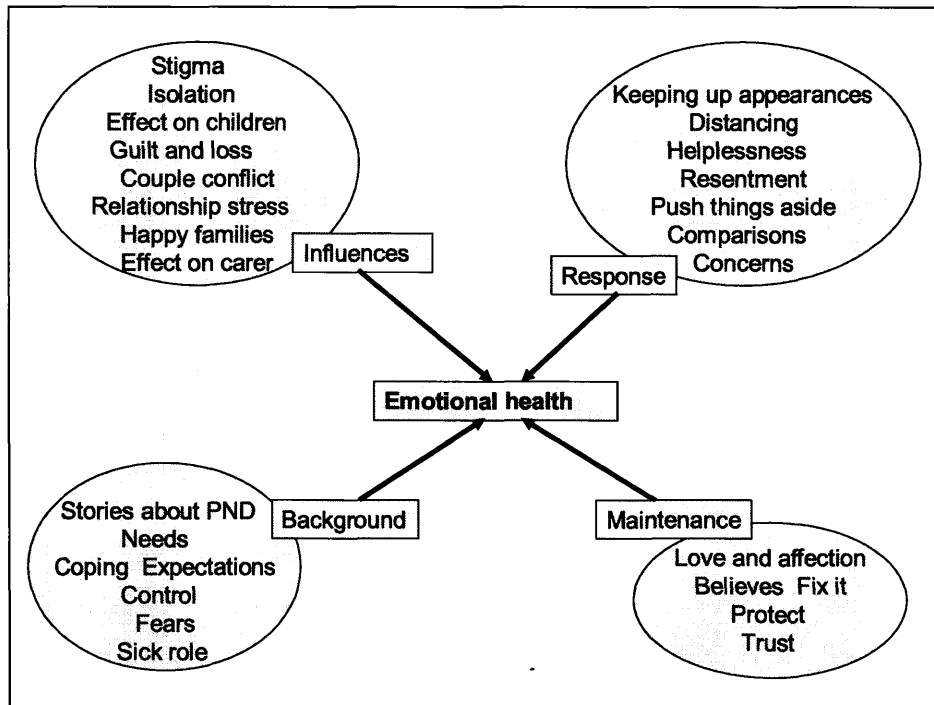


Figure 6 Network: emotional health

5.3.2.1 Influences

The first subcategory (influences) reflects the range of emotions and the sense of isolation generated by postnatal depression. The women, in particular comment on their feelings of guilt. They have lost a happy family, and are aware of the effect of the illness on the children. Other people are perceived to be in happy families, while the couple relationship is under stress. Similar emotional issues affect not only the woman, but also her partner. A sense of stigma further influences the emotional health of the respondents and affects their response to the illness.

Barbara described her feelings of isolation and distance from her partner, Bert. Although she felt strongly for him, she was unable to express her feelings. In her response she tried to recreate not only her own feelings at the time but also speculate about the impact of her behaviour on her partner. The interview provided an opportunity for her to make sense of her feelings retrospectively and create new meaning. Difficulties in communication between the partners are a recurrent theme, in particular the inability to demonstrate feelings of love and affection.

Barbara aged 30, 17 months since diagnosis, interview 2
at times he must have felt that he was totally unloved I mean it hadn't changed the way that I felt about it but maybe I couldn't show it as It was, you know, as if maybe part of me wasn't there any more

Not only the women but also the men commented on their feelings of isolation, their sense of distance from the partner and a loss of intimacy. Jason was one of the youngest fathers. For him the loss of his loving relationship with Jane was particularly challenging. He had moved away from

his own family to live closer to Jane's family. He felt socially isolated and missed his girlfriend's emotional support. Jason not only commented on the loss of the intimacy in the relationship but also indicated that these changes had continued into the present. For him these changes were current as indicated by his use of the present tense.

Jason aged 24, 5 months since diagnosis, interview 3

the depression that she's got seems to have made us lose, as a couple, some of that togetherness Silly things like cuddles and that, we don't do very much now.

These feelings of isolation are not only restricted to the immediate partner but also extend to social interaction with others outside the family. Dana felt removed from the other mothers at the local mother and toddler group. While they appeared to be fully engaged with their children in loving close contact, she felt set apart with a restless baby, feeling unloved by her own child.

Dana aged 36, expecting her second child, interview 2

the other mums seemed to sit and hold their babies and gaze lovingly at them and the babies were sleeping, relaxed in their arms. Whereas this baby was always sitting like tense and always screaming and really, I don't know, she, I just think she just really didn't like me

Comparisons with others and how they appear to manage parenthood strongly influence the respondents' assessment of their own experience. This aspect is developed further in the analysis and informs the definition of 'parenting normality' defined during the final stage of the analysis in chapter seven. Irene picked up this theme. Comparing her own experience with that of other mothers made her feel angry and guilty. This perception of loss of a significant part of her life and her failure to meet the expectations of motherhood are themes shared with the women in the study such as Irene

below. She felt a sense of failure, which remained with her. Her comments illustrated how this had become part of her current self.

Irene aged 26, two years since diagnosis, interview 2

It really changed your life and I get angry that I can't, I don't want to do what say the other mothers do. I've been a failure. I haven't got the energy to do what some of the other mums do or what I see so many mums do.

Feelings of guilt also haunted Dana. She felt rejected and angry towards her fractious baby. Her subsequent inappropriate response then led her to feel guilty. Dana most graphically described her strong response to her child and the negative feelings associated with her.

Dana, interview 2

I can remember one time shaking the arm of the pushchair so she would have been in the thing moving and I just thought "Oh God, what are you doing..... I can remember picking her up and saying "Will you be quiet!" you know. Alarm bells do ring

Others referred to their inability to bond with the baby but did not describe their reaction as openly and vividly. Dana was able to analyse her response and extremes of feelings in retrospect. When I returned to visit Dana and David after a six months interval, they had a new baby in the family. Both parents contrasted their positive response to this more manageable child, their changed approach to their relationship and the absence of these extremes of feelings.

Dana and David, after the arrival of their second child, interview 4

Dana: one really good thing is, is you've been a lot more talkative to me and sort of supportivewe've talked a lot more..... and because she was a totally different baby I think that really helped that she was a much calmer baby.

David: Something else we'd noticed was we'd compare different stages this time compared to last time you didn't feel like crying

All respondents commented that they were aware of a sense of stigma, which influenced their decision making and subsequent response to the diagnosis of postnatal depression. Returning to their experience of postnatal depression after six months, Alan described how this sense of stigma affected communication with even closest family members. Alan used his own experience to generalise to that of others in a similar situation. He cited the experience of others to support his own sense of stigma and its effect on his relationship with Aileen.

Alan, aged 35, engineer, interview 1

I think people with depression and that tend not to like talking about it even to family..... There's kind of a stigma attached to it.

A perception of stigma can further extend to any decision making to seek treatment and medication. Carla avoided medication for a considerable time based on her fear of being labelled and the stigma attached to treatment for a mental health problem.

Carla, aged 29, teacher, interview 2

I didn't want to be on medication.....there is a lot of stigma attached to it but I didn't want to go on medication for that reason

Both respondents' comments reflect the overall sense of separation from others, which all the couples felt strongly.

Freddy attributed this sense of stigma to a perception that physical illness is visible and more accessible to empathy from others. Mental illness, in contrast, is hidden, secret and perceived as private. It should remain removed from the attention of others. His work brought him into close contact

with victims of sexual abuse. Both he and his partner had also received treatment for infertility in the past. The couple frequently drew parallels between infertility and postnatal depression. They felt that both conditions had to be contained within the couple relationship generated by a sense of stigma and a desire for privacy.

Freddy, aged 42, police officer, interview 3

.....there being some form of stigma attached to it..... It's also a thing that if you fall and break your arm, you get a big cast. People see you've got a cast on your arm. "Oh, what a shame. Hope it gets better soon" but You don't go about with a sticker saying "I've been abused. I have postnatal depression. I have depression.... "..... because there's nothing physical that sticks out..... .. it's in your head, it's no a thing that is recognisable straight away. I think the main thing is that it's nobody else's business.

All of the respondents commented on their sense of isolation from the partner, family and peers. This affected their emotional health and influences their decisions with regard to treatment. Both men and women note this perceived sense of stigma, which restricts their ability to share their feelings with others, potentially excluding them from sources of help.

5.3.2.2 Response

The second sub category (response) encompasses the couples' response to these emotional challenges. While the women attempt to keep up appearances, the men express feelings of helplessness and resentment. Often the men comment that they are inclined to push things aside, leading to a distancing from the partner. The couples make a number of comparisons, which are used to assess the impact of the illness and act as markers to chart the progress and severity of the illness. During this process, they compare the effects of mental illness with those of physical illness. They

raise concepts of madness and normality and compare postnatal depression with other depressions.

Aileen hid her feelings from her partner and her family. She needed to convince herself and others that she was 'coping'. This theme is shared with all the mothers in this study. It is associated with a desire to protect those closest to the woman from worry and concern but also a need to maintain a functioning image. The desire to maintain an image of 'normality' is further explored in the next chapter and contributes to the conceptual map of the 'experience of postnatal depression' (chapter 5, figure 11).

Aileen, beautician, prior to her return to work, interview 2

I hide a lot from my family, I don't want them to think, that I'm no coping. So I would hide a lot from him, you know, that would help me, knowing that he is no worrying.

This strategy can cause communication problems when the woman attempts to share her feelings with her partner. Lena described her failed attempts to share her feelings with her partner, Len. Her inability to express her feelings leads to frustration and a sense of sadness at the breakdown in communication between the partners. By blaming herself, Lena appeared to offer a justification for Len's unsympathetic response. Her comment suggested hidden feelings of disappointment in her partner which she might not have felt able to express more openly.

Lena aged 41 older than her husband by 6 years, interview 2

Sometimes I'd talk, you know, try talking to him but it didn't always come over just right really, I don't think and he'd end up getting frustrated with me.

It can also have potentially significant consequences for the recognition of the severity of her illness. Bert was used to his mother keeping her worries to herself and accepted Barbara's lack of communication when she was unwell. Bert appeared to justify his inability to understand Barbara's difficulties by citing his previous family experience. This provided a retrospective justification for his actions and possibly a more socially acceptable explanation than the more negative response implied.

Bert, interview 3

She wouldn't want to put that burden on; she wouldn't want me to worry. My mum is the same, if she has got some worries, she would try and keep it to herself, rather than worry you.

Both partners responded to the emotional challenge of postnatal depression by distancing themselves from each other to protect the partner. While this is perceived to be a useful mechanism to manage the relationship on a day-to-day basis, it has the potential to mask the full extent of her illness.

The men often comment that they withdraw emotionally from the situation at home. George for instance removed himself physically from the room to occupy himself with other activities.

George aged 28, four years younger than his partner, interview 3

Sometimes I would just sort of leave the room. Go and do something, Other times I would just ignore her basically. I just switch off and do something different.

Others, like Freddy, withdrew more permanently by extending working hours or the time spent on hobbies outside the home.

Freddy, six years after his wife's initial diagnosis, interview 1

I just got on with my life. I maybe immersed more in through my hobby at times; I wasn't going home to that! I worked ... I would sometimes choose to get involved in stuff at my work so I didn't have to come home..... (line 372-375) ...I work hard. ..I was at my work to get away from my marriage

Both men's comments illustrate the emotional and physical withdrawal from their partner, which some men adopt to avoid conflict at home. Often they withhold their own feelings of despair from their partner. Harold described his desire to protect Hannah from his negative feelings and additional emotional upset.

Harold, aged 31 years, first child, interview 3

I remember it being tough and I, I was feeling pretty lousy at times as well but I never, ever said anything to her..... I would never, never tell her cos I thought she's got enough..... on her plate dealing with A (the baby) all day.

While the responses to the illness vary, common themes are the feelings of distance and the breakdown in communication described by both men and women. These can arise either from a well-intentioned desire to protect the other partner or a desire to avoid conflict in the home.

5.3.2.3 Background

The third sub category (background) reflects the factors, which influence the couples' emotional response to their difficulties. The needs of the partners, their previous coping mechanisms and their expectations of life as a family are factors to be considered. The women in particular express their concerns about the immediate- and the long term consequences of the illness. They fear a negative reaction from their partner and the wider family but also the effects of the illness particularly on the child's welfare. The respondents draw

on their existing coping mechanisms to provide them with the ability to manage the current challenges. Chris' strong sense of joint responsibility and a belief in personal determination, informed his response to Carla's illness. His self sufficient approach reflected his upbringing in a family with a 'pull yourself together' attitude and work in an environment, where professional distance is encouraged.

Carla, teacher, and Chris, police officer, four months since diagnosis, interview 1

Carla: He says: I feel I have got enough love for the two of us at the moment until you are feeling better.

Chris: I'm a great believer, what is put in front of you, an obstacle for you to get through, over by whatever means, eh, certainly ... All my life

Chris' focus on the practical aspects of the illness affected his response to Carla's depression. He preferred to deal with tangible problems rather than attempt to understand and manage any emotional difficulties. Carla saw herself as self-reliant, making her own decisions and rejecting expressions of sympathy. Chris felt frustrated that he was unable to understand Carla's difficulties. Their response illustrated the tension which can arise between the partners due to different personal backgrounds and coping mechanisms.

Chris, interview 3

I'm alright if I can deal with stuff that I can grab a hold of and do something about I sometimes got a bit hacked off I have to say.....(PF; 177-178) I've always prided myself in the fact that I'm, I'm a strong person and I never have to ask people for help.....(185-189) I'm talking about your big important things. .. I've decided myself how I've felt about things. I've never wanted people to, to feel sorry for me or to ... make decisions for me

In addition, the demands of the new baby and parenthood can affect access to existing coping mechanisms. Evelyn for instance felt unable to have time

for herself, away from the responsibilities of childcare. This lack of personal space caused significant stress and contributed to her emotional difficulties.

Evelyn, aged 36, postnatal depression with all three children, interview 2

A lot of my ways of coping were taken away from me, because you then have a baby. the car was a place for me to be on my own.....you can't be on your own, because baby has got to go too.

Carla and Chris' difference in background and attitudes affected their response to the illness and their management of Carla's depression. Chris preferred to deal with tangible problems rather than attempt to understand and manage any emotional difficulties. Carla saw herself as self-reliant, making her own decisions and was inclined to reject expressions of sympathy. Chris felt frustrated that he was unable to understand her difficulties. This couple's personal background was one of the influences which affected the partners' management of the illness.

Chris, police officer, interview 3

I'm alright if I can deal with stuff that I can grab a hold of and do something about I sometimes got a bit hacked off I have to say.....(PF; 177-178)I've always prided myself in the fact that I'm, I'm a strong person and I never have to ask people for help.....(185-189) I'm talking about your big important things. .. I've decided myself how I've felt about things. I've never wanted people to, to feel sorry for me or to ... make decisions for me

Other background issues, such as work commitments, also affected the couples' emotional health. David for instance had taken on a new set of responsibilities at work, which conflicted with his commitments to his new family. This caused significant personal difficulties for him at the time. With hindsight, he felt these should have been managed differently.

David, technician, 18 months since partner's diagnosis, interview 3

you say oh the wife's not coping and I need to be there and then there's, you're not able to do your job to the best of your abilities so then you feel like maybe you're letting them down.....149-156 I got reports I had to write from work to bring back home and it is the last thing I could have done with and I suppose I should have been the one who was going to work and saying "Look I've got enough on my plate, I don't need this". Rather than do that, I tried to muddle through for some reason, which didn't do anyone any favours.

David's example highlights the significant role, which work commitments played in the lives of the men. They expressed their commitment to support their wives but also felt obligated to their workplace. Disclosing their difficulties at home to obtain support from the workplace was often not an option. This had the effect that the men tried to meet conflicting expectations in their private and public lives, which potentially affected their mental health.

Finally the women raise fears of failure and an inability to cope with the demands of motherhood. Particularly the potential consequences of failure as a mother cause concern and anxiety. Evelyn's comment expressed the fears shared by the women in the study.

Evelyn, seven years since diagnosis, interview 2

My one huge fear was that if I admitted what I was feeling they'd take the baby away

Child protection concerns are an issue not only for the women but for both partners. Edward expressed his fears that he would not be able to cope and lose the baby to others as a consequence of this failure. He realised that these fears were irrational but was determined to keep his family together. Edward admitted to feelings of depression as a result of the difficult times experienced by the couple. In the follow up interview after 6 months, both

were beginning to feel more positive about Evelyn's recovery. Looking back, Edward personal background and expectations of family life had affected his response to Evelyn's illness. He had found it difficult to balance family demands and his own emotional needs. Edward felt that he faced an emotional dilemma. Using quotes from his past, he stressed the urgency of his situation, the tension between his own helplessness and the responsibilities to keep his family together.

Edward, aged 35, urban environment, interview 4

I found it really hard to say 'I'm not coping' and 'why is she like this?' and 'who am I going to call on?' in case everything fell apart... dealing with, helping with the kids and things like that,

The above quotes describe the influence of their personal background and previous stress management mechanisms on the emotional health of both partners. Often their previous background allows them to manage the challenges. Each partner's response is likely to be different, based on their individual life experience. The sense of distance thus generated can be alleviated if the partners clarify their perceptions to each other and coordinate their response. If the illness or the demands of the family deprive the partners of the opportunity to use a previously successful management strategy, this can lead to additional emotional stress. The men comment on the additional demands placed on them in the workplace. There is the potential need to review work and family priorities to maintain the men's emotional health and that of their family. Concerns for the welfare of their children are a further issue. The couples draw on their personal background and life experience to manage the various challenges to their relationship.

5.3.2.4 Maintenance

A range of maintenance factors are described in the fourth subcategory (maintenance), which nurture and sustain the relationship. Love and affection, trust in the partner but also other helpers are important considerations. Both the men and women express a desire to protect their partner but also to fix the problem. In addition the women need to be believed by others.

Aileen and Alan cited their close relationship with each other as the key maintenance factor. Their strong sense of commitment had helped them to overcome an earlier separation. They frequently referred back to this event as the main test of their dedication and compared this to the relatively more manageable problems caused by postnatal depression.

Aileen and Alan, interview 1

Alan: we have got a good loving relationship and

Aileen: but we've been through the worst.....

Alan: .. We wouldnae allow that to happen you know. we have been through the worst

All couples, apart from Frances and Freddy, expressed their commitment to each other in similar terms. Frances and Freddy referred to their long-standing commitment and its significance to the stability of their relationship but cited the need to look after the children as the main reason to stay together.

Not only the couple relationship but also other individuals can contribute to the maintenance of emotional health. Evelyn described other significant

people in her life and the need to be able to trust and feel safe with them. This helped her to access support from a friend with complementary therapy skills. Evelyn not only reflected on her past experience in her comments but suggested that this was an ongoing consideration for her.

Evelyn, interview 2

complementary therapies are wonderful, particularly if you get a therapist, you trust. The guy, that comes and does us, has been a friend for years, but I really trust him But whatever happens, I feel safe.

George also commented on the importance of other close relationships to manage emotional health. For him, trust in the helper and an ability to establish a relationship with the other person were important before he could share intimate thoughts and feelings.

George aged 28, nurse, interview 3

I'll speak to somebody I know well and can trust..... I need to know somebody before I speak to them. I need to know I trust them before I speak to them. Trust isn't easily learned.

Trust in the relationship and the helper is essential to facilitate disclosure of feelings. Still, the desire to protect a close family member or the immediate partner from further emotional distress can override such feelings of trust. The partners often withhold their most personal feelings from each other in an attempt to protect them from additional emotional pain. Evelyn, for instance, withheld her most intimate feelings of distress from Edward in an attempt to protect him from her suffering. At the same time she was aware that this was futile given the strong emotional bond between them. Evelyn commented on her feelings at the time of her illness and used the opportunity

for reflection in the interview to reassess her reaction at the time. With hindsight she regretted excluding Edward from her emotional difficulties.

Evelyn, interview 2

I didn't want him to see me suffering any more than he had to, which was silly, because he knew me well enough then and love me well enough he certainly knew the depth of my pain. I was shutting him out.

Trust and the ability to share emotional distress are important maintenance factors. Couples often develop this understanding and improve their communication with each other as they move towards recovery. David described his change in attitude towards Dana's distress. He had previously tried to 'fix' her problems by offering solutions. He subsequently tried to listen more to his wife and to understand her feelings.

David, 18 months since Dana's diagnosis, interview 1

we still talk about how we are learning to understand about listening rather than trying to, ehm, offer solutions all the time. Just listening to her.

Being listened to and being believed is a particular issue for the women in the study. Frances found it difficult to convince others of her emotional distress after the birth of her first son. She frequently returned to this theme in the interviews. Persuading others of her genuine need proved to be as stressful as the management of her depression itself. Frances' example illustrates most vividly that belief and acceptance are essential health maintenance factors for the women. These are enhanced by opportunities to disclose their distress and gain recognition for their anguish.

Frances, aged 41, previously worked as an administrator, interview 2
eventually I got help but probably some of that was because I looked too, maybe it, you know it didn't look like I was struggling enough. I don't know. I don't know why nobody would believe me

A number of factors contribute to the emotional health of the couples. They experience a sense of isolation from the other partner and their peers, which is reinforced by a fear of labelling and the stigma of a diagnosis of mental illness. The partners respond differently to these challenges: women are more likely to try to 'keep up appearances', men often push the problem aside. Either response can generate feelings of distance and resentment in the relationship. The couples' personal background influences their expectations of parenthood and their response to the illness. Concerns for the welfare of the child are additional fears, which affect the partners' emotional health. Despite these significant challenges, the respondents describe a number of maintenance strategies, which have allowed them to remain in the relationship. A strong sense of commitment, trust and being believed by the partner and others helps to preserve the relationship.

Table 14 below illustrates the patterning of responses in this network for each subcategory by age and social class of the respondents. Responses are distributed across both age and social background. Most couples commented on the factors associated with the first three subcategories: influences, response and background. Fewer respondents commented particularly on the factors which helped them maintain their emotional health. Those that did expressed their commitment to the relationship and the need to be able to trust their partner and others.

Couple	Ages	Occupational classification	Influences	Response	Background	Maintenance
Aileen/Alan	35/30	2	*	*	*	*
Barbara/ Bert	32/30	5	*	*	*	*
Carla/ Chris	27/29	3	*	*	*	0
Dana/ David	36/35	3	*	*	*	*
Evelyn/ Edward	35/36	3	*	*	*	*
Frances/Freddy	42/41	3	*	*	*	*
Gina/ George	28/32	3	0	*	0	*
Hannah/Harold	31/26	3	*	*	*	*
Irene/ Ian	28/26	3	*	*	0	0
Jane/Jason	24/18	unemployed	*	*	*	*
Karen/Kurt	31/30	5	*	*	*	0
Lena/Len	34/41	1	*	*	*	0
Maureen/Mike	30/24	7	*	*	*	*
Nancy/Norman	30/29	1	*	*	*	*
Olive/Oscar	34/35	5	*	*	0	0
Pam/Paul	38/37	2	0	*	*	*
Rachel/Richard	40/39	1	*	*	*	*

Table 14 Patterning of responses for network: emotional health

* indicates that this issue was raised by the partners during at least one of the interviews

0 indicates that this issue was not discussed by the respondents during the interviews

At this early stage of the analysis, each element was tentatively assigned to its respective categories. Often quotes had a range of meanings and could be allocated to more than one code or category. This overlap is apparent in all of the networks. However it also reflects the exploratory nature of this analytical phase and the richness of data.

5.3.3 Access factors

This subcategory network (access factors) identifies a number of issues, which relate to the couples' engagement with those around them and potential sources of help. Three subcategories are described: the representation of the illness, the partners' personal background and the resources, which are available for the couple to access help. Couples describe the factors, which represent the illness to them and influence their understanding of their experience. Each partner's personal background informs their management of the condition and influences their decision to access potential sources of help. Finally, the third subcategory (resources) represents the various support mechanisms, which inform the respondents' management of the condition.

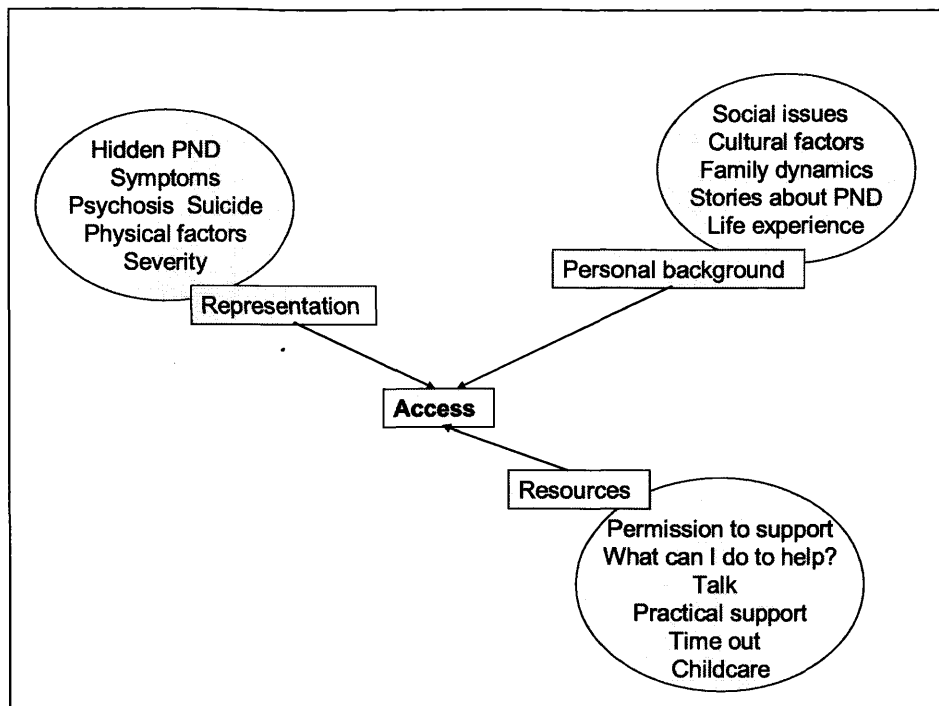


Figure 7 Network: access

5.3.3.1 Representation

The first subcategory (representation) illustrates the factors, which the couples consider in their assessment of the woman's mental health. The type of symptoms experienced and their severity are of concern. Suicidal thoughts and psychosis in particular signify severe mental distress to the partners. Such considerations inform the couples' assessment of their experience and their response.

The experience of childbirth can be overwhelming and perceived as unmanageable by the respondents. Hannah described this sense of inescapable stress when she was faced with the combination of demands made on her. Although previously well able to manage similar conflicts in her workplace, she felt overwhelmed by the experience of childbirth and

motherhood. Hannah felt able to manage each individual factor competently, but was overwhelmed by the combined impact of the various demands of parenthood. Hannah's comments appeared to provide an opportunity to reinterpret her experience as an overwhelming, and hence a less controllable, life event.

Hannah aged 26, first child, partner often away due to work commitments, interview 2

there's usually just one thing that makes other stress there and you can kind of deal with it. But I think just the whole thing – pregnancy, the birth and having the baby is just, it's so huge and it's so in your face

Some of the women experienced suicidal feelings at some point in their illness or speculate on their likely response to them. Such feelings are perceived to be at the top of a hierarchy of symptoms and indicate severe mental distress to the women and their partners. Although Aileen had felt severely stressed, she had only asked Alan to take control of her life when she had felt suicidal. Dana also graphically describes her despair and thoughts of harming her baby. Her feelings reflected her mental distress and provided for her a measure of the severity of her condition. Although Dana acknowledged her negative feelings towards her child, she distanced herself quickly from such attitudes. Her comments reflected her awareness of perceived social norms, which she felt she had contravened. She justified her expression of these feelings as an illustration of the depth of her distress. Through the use of the past tense she placed her negative attitudes in her previous life, from which she distanced herself in the interview.

Dana aged 35, nurse, interview 2

I nearly thought I could just, you know, put a pillow over her and sort of go and hang myself sort of thing, which is the only time I ever felt like that! I never would have done anything or anything like that but that's where I think, when you really know that you hit a rock bottom patch

In addition madness is a theme for some of the women. Carla in particular spoke about her fears and loss of control. She did not share her feelings with Chris, but started to worry about her 'madness' in the following weeks. She described a range of symptoms such as forgetfulness, short temper and unexpected changes of mood, which made her feel 'out of control' and 'mad'. Chris characterised her as an unpredictable 'Jekyll and Hyde' character. She could respond to an affectionate pat either relaxed and playful or angry and aggressive. Her fears were confirmed when others treated her as 'mad'. These considerations form part of the participants' assessment of the woman's health during and after postnatal depression. Carla frequently used the term 'mental' when she described her emotional difficulties. Her strong feelings of insecurity were reflected in her repeated confirmation that she was not 'mad'. Having recently been diagnosed with postnatal depression, she may have felt particularly vulnerable and needed to reaffirm her 'normality' to herself and her listener.

Carla, interview 2

You feel like you're mad and then people like that treat you like you're mad and then you start having to fight your corner but I'm no mental, honestly, I'm no mental!

The couples' understanding of the illness contributes to their response. The women feel able to manage a significant amount of distress, but are overwhelmed by the combined demands of the various stressors of

parenthood. Loss of control and descent into madness are real fears. Associated feelings of despair can trigger suicidal feelings and a wish to withdraw permanently from distress. Only when such a crisis is reached do some of the women approach their partner for help. Others never share their despair with those closest to them until much later. The representation of postnatal depression is consequently a significant element in the couples' assessment of the severity of the illness.

5.3.3.2 Personal background

The second subcategory (personal background) relates to the issues which impact on the couple's interaction with the family and various psychosocial factors. These relate to existing family dynamics and relationships with parents and other family members. The social interaction with them and their response to other requests for help influence the couples' decision to seek help. Geographical distance from immediate family members and other potential helpers is of concern to some but not all respondents.

Their previous experience with family members informs how well the respondents feel able to approach them for help. Chris felt that his family had been unsupportive when his mother had died. Their inability to respond to his emotional distress at that time affected his decision not to share his partner's diagnosis of postnatal depression with his relatives.

Chris, one older child from previous relationship, interview 3
sometimes family are quite judgmental I think. In going through past experiences I had all these points that I needed to get across to my family and they didn't seem to want to accept my points of view about how I felt

Expectations of support are informed by the couples' past experience and, for some, the geographical distance of the helper. When the extended family lives at a distance, this can be barrier to recognition and support. For instance Dana and David felt that communication with distant relatives was difficult. It affected their ability to recognise Dana's early symptoms and left them feeling isolated. David speculated about the potential benefits of family support. This perspective might have helped him to alleviate his own feelings of failure to recognise Dana's difficulties early on.

David, living in rural area, family living at distance, interview 1
we didn't have any family here, either, who would maybe recognise the signs or see that anything was wrong, because they are all so far away.

Close contact with other family members is valued to identify problems early and offer support. Couples who feel isolated from their families often also comment on other family issues and communication problems. Not all couples share David and Dana's perspective. They use telephone conversations and extended family visits to overcome geographical distance.

Regardless of geographical distance, the family's anticipated reaction to a diagnosis of postnatal depression is a further consideration. It influences information sharing and the decision to access help from this resource. Carla, for instance, drew a clear distinction between one family member and another. She used her existing knowledge of her two relatives to share her concerns with one and exclude the other: her sister-in-law was perceived to be non-judgemental and easy to talk to, her own sister was seen to be unsympathetic and excluded from any personal information.

Carla, four months since diagnosis, close local family ties, interview 2
I found it easier speaking to my sister in law because I didnae want my sister thinking I was a failure Whereas it was easier speaking to my sister in law because I didnae feel she would judge me as much somehow.

The women fear that they will be judged a failure by their partners and close relatives. This also extends to the men who exclude particular members of their family from confidences in order to protect the well being of their partner. Freddy felt that his mother-in-law would be unsympathetic and unlikely to respond effectively to her daughter's depression. The respondents' personal background affects their assessment of the potential helper and their request for help.

5.3.3.3 Resources

The third subcategory (resources) relates specifically to issues around the facilitators of support, the willingness of the family to be involved and helpful support strategies. Bert focused his efforts to provide practical support to Barbara and reduce the burden of repetitive chores. He felt that his help would allow Barbara to feel less confined by her household duties. Hannah described the benefits of Harold's support during her illness. She was able to take time out from routine tasks in the house and engage in independent activities outside the home. The couples commented on various practical support strategies and on the benefits, which a release from routine tasks in the home can provide for the mother. Hannah listed a range of activities, which she had found to be beneficial. These reflected the sense of urgency felt by her to break away from household chores and reclaim personal independence.

Hannah, 21 months since diagnosis, family living a distance away, interview 2
to get away from the house, get away from the, you know, the routine of bottles and nappies and baths and housework and things..... to have time out whether it's just to go away shopping on my own or something.

Practical help is an important resource, and access to it is a recurrent theme throughout the interviews. Even if practical help is available, both the potential helper and the woman need to be able to recognise that postnatal depression itself can be a barrier to accessing this help. The woman needs to be ready to receive help and give permission to be supported. The potential helper needs to be ready to listen and help. Only when these conditions are met, can help be accessed effectively. Karen described how her partner's sensitivity allowed her to accept his help. Although he found it difficult to fully understand his wife's distress, Kurt's efforts to offer help and emotional support were commended. A degree of suppressed disappointment was noticeable in Karen's comment. Her subsequent efforts to praise Kurt's help served to reduce any suggestion that this had been the cause of tension between the partners. This might have been due to a desire to portray the relationship in a positive light or a more favourable re-evaluation after a period of time.

Karen aged 30, first child, married shortly before the birth, interview 2
As much as he didn't get it, he kind of, he was understanding and supportive and didn't make a big deal. So that was good. That helped.

Bert felt there were limits to the help he was able to provide. He found the additional input from a sympathetic outsider, in this case the family's community psychiatric nurse, useful. This helped the couple bridge some of the gaps in communication identified earlier.

Bert, worked locally in small business, interview 3

To try and understand what she was going through, trying to help her was hard at first. But I think she got more help from the community psychiatric nurse, the fact that he was somebody on the outside looking Because sometimes, when you are in the situation, you can't see the wood for the trees type thing.

At times all attempts to help can be rejected due to the woman's emotional changes. Helpers sometimes need to be prepared to persevere with their offer or change their approach. Chris found it useful to allow Carla space to talk to him of her concerns in her own time.

Chris, first child in this relationship, four months since Carla's diagnosis

I eventually worked out myself just sort of take a step back and let it..... If she wanted to talk to me, she wanted to talk to me eh.

The attitude of the potential helper and the woman's readiness to accept help are both important elements of this category network. Practical support is valued and can provide time out from the demands of the family. Often the helper needs to persevere with offers of help or review the approach.

Table 15 illustrates the patterning of responses in this network for each subcategory by age and social class of the respondents. Responses are distributed across both age and social background.

Couple	Ages	Occupational classification	Representation	Personal background	Resources
Aileen/Alan	35/30	2	*	0	*
Barbara/ Bert	32/30	5	*	*	*
Carla/ Chris	27/29	3	*	*	*
Dana/ David	36/35	3	*	0	0
Evelyn/ Edward	35/36	3	*	0	*
Frances/Freddy	42/41	3	*	*	*
Gina/ George	28/32	3	*	*	0
Hannah/Harold	31/26	3	*	*	*
Irene/ Ian	28/26	3	*	*	*
Jane/Jason	24/18	unemployed	*	*	*
Karen/Kurt	31/30	5	*	*	*
Lena/Len	34/41	1	*	*	0
Maureen/Mike	30/24	7	*	*	*
Nancy/Norman	30/29	1	*	*	*
Olive/Oscar	34/35	5	0	*	*
Pam/Paul	38/37	2	0	0	0
Rachel/Richard	40/39	1	0	*	*

Table 15 Patterning of responses for network: access

* indicates that this issue was raised by the partners during at least one of the interviews

0 indicates that this issue was not discussed by the respondents during the interviews

The network 'access' contains three elements. The couples consider a number of factors, which represent postnatal depression to them. These inform their assessment of the experience based on their interpretation of the symptoms and attitudes to mental illness. Access to support is further affected by the respondents' personal background: their family dynamics, social issues and their previous experience of support. Finally couples consider the potential resources accessible to them such as practical support, the attitude of the helper and the ability of the woman to accept the support offered.

A tentative hypothesis emerged from this network, which proposes a dynamic process of 'help seeking' influenced by the couples' previous experience of illness, personal attitudes and resources. This hypothesis was developed further into the core category 'process to seek help' and discussed in detail in chapter

5.3.4 Roles and gender

This network of subcategories relates to the influence of role perceptions and gender on the couples' understanding and response to the illness. The inclusion of the partners' individual background in this network specifically reflects the influence of life experience, expectations and family dynamics on the couples' experience. The third component of this network, the man's response to his partner's illness, is informed by his understanding of the role of father and husband.

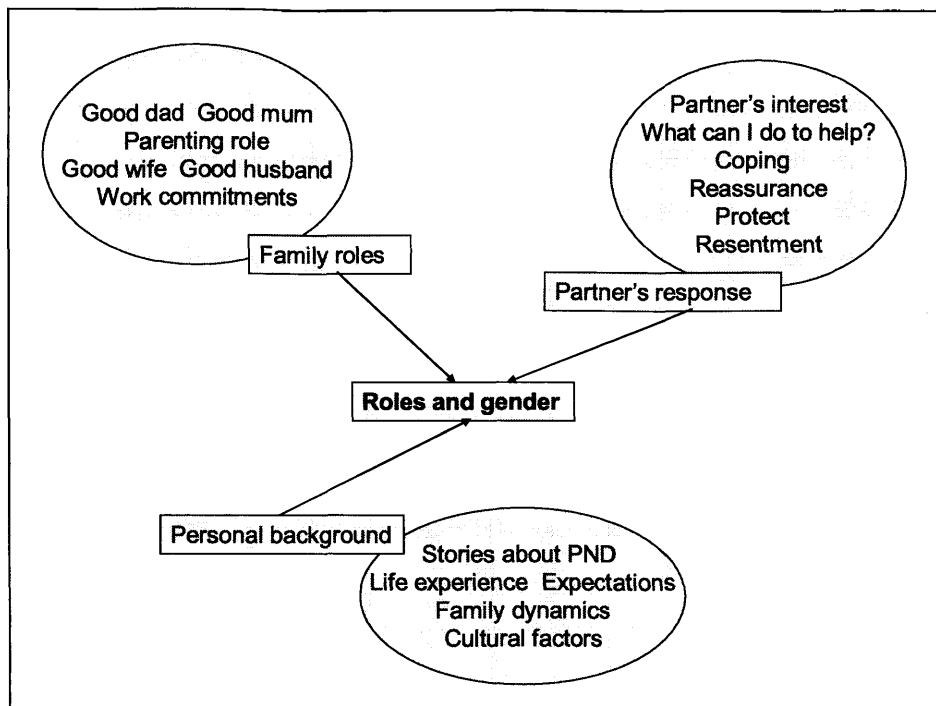


Figure 8 Network: roles and gender

5.3.4.1 Family roles

The first subcategory (family roles) relates to the respondents' understanding of their position within the family, their function as good parents and the conflicts between the demands of family- and working life. The father is expected to act as the 'good dad' and partner, although work commitments can get in the way of fulfilling this role. Some partners accept this role, while others cite work as a reason to reduce some of these expectations.

The partners' perception and understanding of their roles range from one of conflict to a shared commitment of responsibilities. Some of these perspectives are illustrated by the following comments. For instance Frances and Freddy perceived their role and functions within the family very differently. Freddy felt that he continued to be involved with his family after

the birth of the new baby. He fulfilled his role as a good husband by completing various household chores.

Freddy, his partner, Frances, had episodes of depression after the birth of both children, interview 1

things didn't change that awfy much after, after the boys were here. I still did the shopping. I still did the hovering. Still drove, F cannae drive, so that was sort of it.

His wife, Frances, focused on her husband's work commitment and his continued involvement with his leisure activities. Throughout the interviews, she contrasted the perceived changes in her own role after the birth of her child with the lack of change in Freddy's life. For Frances, work meant the possibility of escape and recognition of an important contribution which she felt no longer able to make. Freddy had remained in the workplace and was able to use his work to obtain space for himself. This was a cause of resentment for Frances. Freddy admitted at other stages of the interview that he did work longer hours away from home to escape the difficulties at home. The differences in the partners' perception of their roles suggested a potential conflict in the couple relationship.

Frances aged 42, episodes of depression after birth of both children, interview 1

I found was that his life pretty much staid the same, you know. he went to work and I was left Nobody ever said to him about his hobbies "that's nice you've kept up a wee interest now that the baby's here..... I was just supposed to sit at home and knit bootees or something.

In contrast, David felt that work demands interfered with his ability to meet his family responsibilities. The combined demands of a new, promoted post and his partner's illness nearly proved too much stress for him. Later in the interview and with the benefit of hindsight, he regretted that he was unable to

assert his own needs at work and actively reduce the pressures put on him by his employer. The tension created by this need to balance work- and family life caused considerable stress for him.

David, interview 3

at that particular time I had a lot more stress than I would normally have anyway, even without the post natal depression.it was almost just too much.

In contrast Bert did not experience such a tension. Although concerned about his partner's health, he felt that he was able to combine support for his wife at home with his work. His comments illustrate how this father was able to manage the difficulties at home by separating two role functions: the supportive husband and the employee.

Bert, interview 3

when I was at my work, I did think of it..... I wouldn't say it affected my work too much, I always knew I was always coming back to help her.

Table 16 illustrates the distribution of men's conflicting demands of home and work by age and social class. Some men cited their work commitments as predominant, superceding their partner's expectation of support. Their background placed them in the upper aspects of the social spectrum. Other men from a similar social class did not express these sentiments, although a number commented on the tension between their need to manage the tension between work and home during their partner's illness.

Couple	Ages	Occupational classification	Family roles
Aileen/Alan	35/30	2	Focus on home
Barbara/ Bert	32/30	5	Tension between home and work
Carla/ Chris	27/29	3	Focus on home
Dana/ David	36/35	3	Tension between home and work
Evelyn/ Edward	35/36	3	Focus on home
Frances/Freddy	42/41	3	Focus on work
Gina/ George	28/32	3	Focus on home
Hannah/Harold	31/26	3	Tension between home and work
Irene/ Ian	28/26	3	Tension between home and work
Jane/Jason	24/18	unemployed	Focus on home
Karen/Kurt	31/30	5	Tension between home and work
Lena/Len	34/41	1	Focus on work
Maureen/Mike	30/24	7	Focus on home
Nancy/Norman	30/29	1	Focus on home
Olive/Oscar	34/35	5	Tension between home and work
Pam/Paul	38/37	2	0
Rachel/Richard	40/39	1	0

Table 16 Patterning of men's conflicting role demands

0 indicates that this issue was not discussed by the respondents during the interviews

Being a 'good father' and husband is important to all of the respondents. Carla and Chris summarised the characteristics of this role. For Carla it was important to receive help from Chris and rely on him to manage the family's problems. Although this was stressful for him, his love for his family and children motivated Chris to be a good father. He saw this as an even greater achievement since Chris' own upbringing did not prepare him for this role. Neither Carla nor Chris felt that Chris' parents provided a good example of good parenting.

Carla and Chris, interview 1

Carla: I have had help, I have had lots of support.

Chris: I have had my bairns

Carla: and, ehm, he has just kind of held on tight and ride the storm if you like. But he is an extremely, he is an exceptionally good dad; he really is..... because your mum is not a natural grandparent.

For the women, being perceived by others to be a good wife and mother is a key concern. This need to appear to fulfil the role effectively can affect disclosure of problems and potentially block access to sources of help. Dana was concerned that she would be judged on her performance of her role as 'good mother'. In her response she attempted to explore her own understanding of the issues and her motivation for her actions. Her use of the present tense situated her reflection in the time of the interview. She drew conclusions from her past experience and included them in her subsequent evaluation, speculating about the social issues which she felt had influenced her feelings at the time. These appeared to have a continuing relevance for her ongoing analysis of her experience.

Dana, interview 2

You definitely don't talk about emotional things cos you don't want to seem a bad mother. I think that's the underlying thing.You just don't want to be seen as a bad mother.

The ultimate sanction for being a bad mother is the removal of the child from the mother's care. Irene summed up this very serious concern. She talked about her real fear of the loss of her child as a result of being labelled in this way. These were real and ongoing concerns, which she expressed through her use of the present tense in her comments. She reaffirmed her love for her children in her statement in an effort to underline her ongoing commitment to them and possibly as a refutation of any perceived accusations to the contrary.

Irene aged 26, postnatal depression after birth of twins, interview 2

I don't want the kids being taken away from me as I feel a bad mum as it is, you know. I don't want to be away from them cos I do love them.

Despite the difficulties, which postnatal depression brings with it, all of the women expressed this fear and returned to the need to be a good mother looking after her children. Although a few women did not comment on this aspect of their role, most respondents did refer to their concerns and their desire to act as good mothers. Not only first time mothers but also women with more than one child raised these issues. Factors such as age, social class or parity did not appear to affect these women's perception of their role. Their personal background and life experience were of greater significance in this instance. Table 17 illustrates the patterning of responses in relation to their role as 'good mother' and wife by age, social background and number of children.

Couple	Ages	Occupational classification	Number of children	Good mother/ wife
Aileen/Alan	35/30	2	2	*
Barbara/ Bert	32/30	5	2	*
Carla/ Chris	27/29	3	3	*
Dana/ David	36/35	3	2	*
Evelyn/ Edward	35/36	3	3	*
Frances/Freddy	42/41	3	2	*
Gina/ George	28/32	3	2	0
Hannah/Harold	31/26	3	1	*
Irene/ Ian	28/26	3	2- twins	*
Jane/Jason	24/18	unemployed	1	*
Karen/Kurt	31/30	5	1	*
Lena/Len	34/41	1	2	*
Maureen/Mike	30/24	7	1	*
Nancy/Norman	30/29	1	1	0
Olive/Oscar	34/35	5	2	*
Pam/Paul	38/37	2	2	0
Rachel/Richard	40/39	1	1	0

Table 17 Patterning of responses relating to the role of 'good mother'

* indicates that this issue was raised by the partners during at least one of the interviews

0 indicates that this issue was not discussed by the respondents during the interviews

When the woman is no longer able to fulfil her domestic role as carer and mother, this becomes an additional significant stress to her emotional health and the relationship. For instance Mike took over a significant part of Maureen's role as mother and wife. Since she felt that domestic and childcare responsibilities were a central aspect of her role, Maureen expressed her guilt and feelings of failure.

Maureen aged 24, nursery nurse, interview 1

When it's a role reversal and you're not used to doing that role, you know, it puts extra strains on I basically fed the baby, that's all I did..... and got myself ready, so he had to do everything else, tidying, cooking, getting the baby ready and bath her

Both partners experience significant challenges to their roles in the couple relationship. Work can be perceived as a welcome escape from the new responsibilities of motherhood. It can also cause feelings of resentment in the woman when her partner is perceived to use his work commitments to distance himself from his parental role. The role of work in the couples' definition of normality is discussed later in this thesis. The men can experience tension between the demands of their role as worker, good husband and carer. While most men manage this conflict, some use their work commitments to avoid problems at home. Others find it difficult to manage the dual demands of work and family life and experience emotional distress themselves. It is important for the men to be seen to be good fathers and husbands, characteristics for which their partners commend them. Being a good parent and wife is similarly important for the women, for whom this is a central aspect of their role. Postnatal depression can compromise the woman's ability to function effectively and take care of her family. Postnatal

depression can affect these roles and generate feelings of guilt. The couples' lived experience as parents can differ significantly from their expectations.

5.3.4.2 Personal background

The second subcategory (personal background) is shared with other networks and relates specifically to the couples' life experience and the influence of their expectations on their role and function as parents. Alan's personal background and previous experiences of relationships for instance influenced his response to his wife's illness. He saw himself as a self reliant person used to making his own decisions without talking to others. Any particular difficulties should be kept within the family and not shared with others. Alan valued the companionship of other men but did not use friendships to share his concerns. He saw self reliance as integral to the male role, a view shared by the other men in the study.

Alan, interview 1

it's no the things I would really discuss with people, you know, about how she was.... (line 393-395) it's no because of the type of friendships. It's, it's just me as a person and pretty much guys, as a whole, wouldn't do that..... 970-973 I do my own thinking. I just think it's more information than they need.

Alan further suggested that women are more likely to utilise friendship groups to manage emotional stressors. Men were less likely to talk about their difficulties, while women preferred to share their problems with others. Other men also commented on this perceived gender difference. This gendered response to the management of emotional problems is later revisited when the men talked about the relevance of various support groups to them.

5.3.4.3 Partner's response

Finally, the partner's response to the woman's illness (third subcategory) is informed by his perception of his role as husband and father, his desire to protect his wife from distress and the coping responses he utilises in other aspects of his life. While some men openly declare their interest and offer their help, others feel resentful of the illness and its effect on the couple relationship. The responses of most of the men included a reference to their desire to protect their home and family from unwelcome intrusion. George in particular referred to the man's role as protector of the home but also his desire to contain any problems within the family unit. He shared this sentiment with the other men such as Chris and Harold. It is likely that the men expressed these views to justify actions, which might have been perceived as unsympathetic. Citing perceived social norms of their role as men might have allowed them to justify their actions and set them apart from their partners.

George aged 28, nurse, interview 3

Men are different. We don't like to, we don't like people looking in the window, so to speak. They just like to close the door and keep it to ourselves.

Interviewer: I WONDER WHAT THAT IS ABOUT.

George: Genetic. Neanderthal. The Neanderthal gene must be. (laughter) I don't know. Man's meant to be the protector hasn't he?

Chris felt that any difficulties should remain within the family home. He considered himself to be its gatekeeper to the world outside but recognised possible limits to this self sufficiency and the need to share some concerns with others. For George and Chris, their role as husband and father demanded that they managed the family's problems independently for as

long as possible. Only when they judged that these might exceed their own abilities to respond, would they have involved others.

Harold aged 31, army corporal, interview 3

I'm not the kind of person that would go round telling anybody and everybody what's going on in our lives. I think what goes in these 4 walls stays between these 4 walls unless it's something drastic – unless it's something really, really drastic that somebody's got to find out.

Most of the men commented strongly that they felt irritated with the stresses experienced at home. Freddy's comments reflected the lack of satisfaction with the relationship, which Frances and Freddy felt. Although Frances had been ill a significant number of years previously, both expressed feelings of dissatisfaction with each other throughout the interviews. In his recollection of his experience at the time, Freddy described his feelings of irritation, which kept him away from home.

Freddy, police officer, six years since Frances' diagnosis, interview 1

I just got on with my life..... I wasn't going home to that! I worked, I work long hours anyway. I would sometimes choose to get involved in stuff at my work so I didn't have to come home.

Freddy expressed his negative feelings most openly of all the men. This might have been due to the fact that he and Frances had been together for a long time and felt comfortable to express negative feelings in front of a stranger. He might have also used the formal context of the interview to express his feelings and to underline his sense of independence. Freddy's comment reflected one aspect of the spectrum of feelings expressed by the men.

Table 18 below illustrates the range of the men's attitudes to their partner's illness. Most men, who commented on their attitude to their partner's illness, talked about their desire to protect her and their family from intrusion and harm. Some men also felt bitter about their partner's illness and its effect on the couple relationship. While most men expressed a desire to protect their partner, some focussed on their resentment. Others were ambiguous in their attitude. They felt they should protect their partner but also disliked the stress the illness had imposed on their daily life. Neither social class nor the men's ages appeared to be significant factors in this distribution of responses.

Couple	Ages	Occupational classification	Partner's response
Aileen/Alan	35/30	2	Desire to protect
Barbara/ Bert	32/30	5	Desire to protect
Carla/ Chris	27/29	3	0
Dana/ David	36/35	3	0
Evelyn/ Edward	35/36	3	0
Frances/Freddy	42/41	3	Feelings of resentment
Gina/ George	28/32	3	Desire to protect
Hannah/Harold	31/26	3	Desire to protect
Irene/ Ian	28/26	3	Desire to protect/ feelings of resentment
Jane/Jason	24/18	unemployed	Desire to protect/ feelings of resentment
Karen/Kurt	31/30	5	Desire to protect
Lena/Len	34/41	1	Desire to protect
Maureen/Mike	30/24	7	Desire to protect
Nancy/Norman	30/29	1	Desire to protect
Olive/Oscar	34/35	5	Feelings of resentment
Pam/Paul	38/37	2	Desire to protect/ feelings of resentment
Rachel/Richard	40/39	1	0

Table 18 Distribution of men's responses to their partner's illness

* indicates that this issue was raised by the partners during at least one of the interviews

0 indicates that this issue was not discussed by the respondents during the interviews

The respondents feel that they should fulfil their role as good husband, father, wife or mother. They judge themselves and their respective partner against their own previous experience, their personal expectations of themselves and the other partner but also the roles, which they feel they need to fulfil. The men react in different ways to the women's illness. Some try to be actively involved in supporting their partner while at the same time managing their work commitments. Others struggle with the emotional upset to the detriment of their own health. Others, again, make a decision to withdraw from the difficulties at home into work and leisure. Table 19 illustrates the patterning of responses for this network for each subcategory by age and social class of the respondents. Responses are distributed across both age and social background.

Couple	Ages	Occupational classification	Family roles	Personal background	Partner's response
Aileen/Alan	35/30	2	*	*	*
Barbara/ Bert	32/30	5	*	*	*
Carla/ Chris	27/29	3	*	*	0
Dana/ David	36/35	3	*	*	0
Evelyn/ Edward	35/36	3	*	*	0
Frances/Freddy	42/41	3	*	*	*
Gina/ George	28/32	3	*	*	*
Hannah/Harold	31/26	3	*	*	*
Irene/ Ian	28/26	3	*	0	*
Jane/Jason	24/18	unemployed	*	*	*
Karen/Kurt	31/30	5	*	*	*
Lena/Len	34/41	1	*	*	*
Maureen/Mike	30/24	7	*	0	*
Nancy/Norman	30/29	1	*	*	*
Olive/Oscar	34/35	5	*	0	*
Pam/Paul	38/37	2	0	*	*
Rachel/Richard	40/39	1	0	*	0

Table 19 Patterning of responses for network: roles and gender

* indicates that this issue was raised by the partners during at least one of the interviews

0 indicates that this issue was not discussed by the respondents during the interviews

5.3.5 Professionals

This network of sub categories relates to the activities of professionals. It describes the specific issues raised by the respondents in relation to medication and professional health care services. Professionals carry out a range of activities to identify, assess and treat the women for postnatal depression. The respondents comment on the perceived benefits and limitations of these actions. Of particular concern is the professional decision making around the choice and prescription of medication. How information about treatment options and compliance is shared is also important. Finally, all respondents are aware that limited resources and service constraints can affect their care. The network 'professionals' describes an area of considerable concern to the respondents and of particular interest to professionals delivering these services.

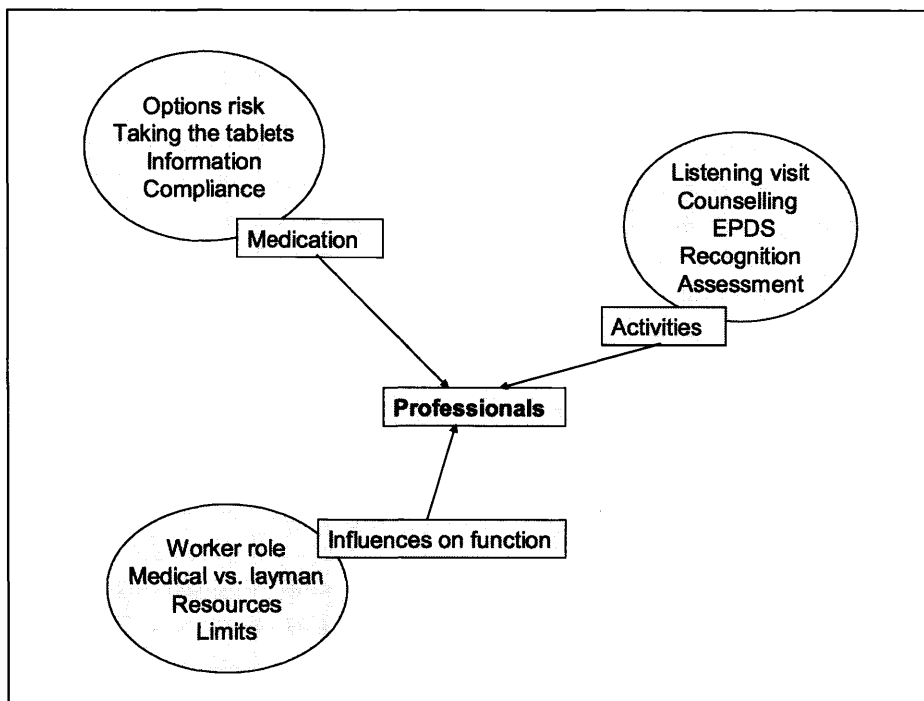


Figure 9 Network: professionals

5.3.5.1 Activities

The recognition of postnatal depression, the use of the Edinburgh Postnatal Depression Scale and various listening activities are among the various professional activities included in the first subcategory (activities). It is the primary responsibility of professionals to identify and diagnose postnatal depression. The Edinburgh Postnatal Depression Scale is the tool most used as part of this process. It is important the professionals are able to recognise that the woman's experience is 'not normal' and requires treatment. It opens the doors for treatment in the form of medication and psychotherapeutic activities such as listening visits and counselling interventions. Professionals should be able to note any changes, diagnose a potential deviation from the expected path and provide guidance to resolve the difficulties. Early and timely diagnosis is essential as part of this process to reduce potential complications and optimise access to appropriate support mechanisms. For instance both Hannah and Evelyn located the responsibility for the diagnosis of postnatal depression with the healthcare professional.

Hannah, diagnosis made three months after child's birth, interview 2

You kind of rely on, you know, the health professionals to be there sort of to spot it, you know, and to help you along a bit.

While the onus of diagnosis is placed firmly with the professional, this identification process is complex due to the inherent problems of disclosure. Dana recognised the efforts of the professionals and their use of screening to aid the diagnostic process but also highlighted the woman's contribution to this process. Her desire to maintain a functioning image to the world can

affect the woman's ability to admit any problems to a potential helper. Dana recognised this inherent conflict in her response.

Dana, nurse, interview 2

I think that when they come and do that score on you, it's very easy to cheat and I think it's very easy to put on a, you know, you tidy your house and sort of everything is fine and then..... you just feel like you have to pretend and you walk away, tears start coming

Resolving the conflict between disclosure and the need to maintain a functioning image is often the result of a long, internal struggle. The need to be believed is a key requisite of any therapeutic encounter with a professional who is responsible for the provision of appropriate treatment. The woman has a reasonable and rightful expectation to have her trust rewarded in a mutual relationship with her helper. Karen for instance expected her honesty to be acknowledged by the professional and to receive prompt, appropriate action in response. She summarised this sentiment in her comment.

Karen, gardener, rural environment, interview 2

it's very important that if a person's made the effort to go to the Doctor's and be honest enough to say "Hey, I'm not coping" that they really take that on board and give you the right tablet.

Often these expectations are not necessarily met as Jane noted. She had experience of both medication and listening interventions. Jane's more favourable assessment of the counselling intervention might have been prompted by a desire to register her negative feelings towards other healthcare provisions. Both Jane and Jason frequently contrasted not only different services but also the help available in different geographical areas.

The interviews provided an opportunity for them to express their sense that they could have received more effective help.

Jane, aged 18 years, unemployed, interview 2

you talk about how you're feeling that week and things like that was helpful cos I said a lot of things that I wasn't even aware of that were inside of me....but (307-309) he [the doctor] just asked me how I'd been feeling and put me on some tablets. That was basically all that they do at that Doctor's surgery

Her comparison of the treatments offered by different health professionals highlighted the significance of the manner in which these were administered. The prescription of medication is perceived to be a simple, administrative task. In contrast, listening contacts are interpreted as an opportunity for the woman to explore her experience. They are seen to be more personalised and helpful. Women need to feel that their trust in the helper is rewarded by treatment which is appropriate as well as personalised.

At times, it is necessary to seek out other interventions and involve other agencies. After a long search and various professional contacts, Frances received cognitive behaviour therapy at the local hospital. She felt anxious prior to the encounter. Sitting in a general out patient area, she felt stigmatised as she waited to be seen for her first appointment. Although the actual contact with the therapist was less threatening than she had anticipated, she still felt intimidated and found the discussion of her personal, intimate experience extremely challenging. Frances felt a sense of relief that she had eventually been able to access this very personal form of treatment. Her experience illustrated that of the other women who found it difficult to

discuss their feelings. They need to be able to develop a relationship with the potential helper to benefit from the contact.

Frances, interview 1

It was awful you've to sit in a room about 6 foot by 8 and talk to a complete stranger and I couldn't even talk to my mum or my husband or my best friend about it.

All respondents describe the activities of various professional workers in detail. On the whole the onus of recognition and treatment lies firmly with the professional worker although individual barriers to this process are acknowledged. Contact with workers can be varied, ranging from functional prescribing encounters to deeply personal interventions. These can be perceived to be either helpful and cathartic or threatening and very emotional.

5.3.5.2 Medication

Medication and the decisions surrounding its prescription form a distinct subcategory (medication). This aspect of their care generates significant anxieties in the respondents and has implications for compliance. The opportunity to discuss treatment options, in particular the potential side effects of medication, is valued. Specifically the men comment that this information helps to alleviate anxieties and normalises their experience. Compliance with the prescribed medication is of particular concern for the women. It is important that the prescribing professional demonstrates interest and ensures compliance through regular follow up. Often the decision to accept medication is pragmatic due to an understanding that spontaneous

improvement is unlikely or other sources of help are unavailable. Karen for example felt socially isolated from her own family living in a rural setting without transport. Her decision to accept medication reflected her realisation that she required help to resolve her difficulties. A perceived lack of social support contributed to Karen's decision to seek medical help and accept medication.

Karen, rural environment, interview 2

because there wasn't a support I'll need to go to the Doctor's and get help medicine-wise because there aren't the other sources of help around

Some mothers, like Karen, reached their decision alone while others, like Barbara, discussed their options with a professional. Barbara's health visitor helped her to explore her treatment options gradually and to consider additional help and medication.

Barbara aged 30, medical secretary, interview 1

she said: 'I really think, you should go and see the doctor. What do you think about medication?' I said to her: 'I'm not really for it at first, but eventually I realised myself that I think I'm really needing this, because I'm not going to do without the medication

The women see medication as a late treatment option, which they gradually come to accept after they have explored other possibilities and tried to resolve their problems independently without additional help. This is particularly the case for women experiencing their first episode of postnatal depression. This exploration is less protracted during a recurrent episode of depression.

While the women describe the complexities of this decision making process, the men focus on the potentially negative impact of the treatment on their partner, it is particularly important for the men to understand the medication and its potential side effect. Bert, Barbara's partner, found it helpful that the healthcare worker offered an accessible explanation, which he found easy to understand. Once his questions had been answered, he accepted the need for the treatment.

Bert, interview 3

When she had explained it that there wasn't going to be any side effects, I was quite happy with that.

David expressed a similar need to understand Dana's illness. He wanted to be reassured about any potential side effects of the medication. David needed to be able to access this information in a useable format but felt excluded from any relevant discussions. Instead, he felt dependent on Dana to pass on information, which she had been given by the professionals. David reflected with hindsight on a more effective strategy. Placing the responsibility for information on others might have helped him to justify his own possible lack of action at the time of Dana's illness.

David, interview 3

I didn't really know what, how they work, what they do..... if I had been involved and maybe somebody had said to me "oh this is, this is how they work and they are not addictive", or....." this is how it's all planned out", then that would have set my mind at rest.

These men's comments reflect their desire to be involved in the planning of care for their wives. They have a sense that they are on the periphery of care but want to be part of the process.

Once the various concerns have been alleviated, the course of treatment thus arrived at should be effective and uneventful. Carla found that this was not necessarily the case. The medication initially made her feel significantly worse. Her fear that this was likely to continue indefinitely confirmed her previous concerns. Despite her doubts, she did persevere and eventually felt the benefits of the medication.

Carla, teacher, one older child from a previous relationship, interview 2
First couple of days on the tablets, I actually did want to kill myself I felt so bad. I wanted to be sick all the time.... It was hideous. ... I've never ever wanted to take drugs and then to get them off the Doctor and make you feel like that – it was horrible!

She expressed her disappointment that she had not been forewarned about the severe side effects, which she did experience. This undermined her trust in the prescribing practitioner. Despite her unease she did not feel able to discuss these concerns with her General Practitioner.

Carla, interview 2
I never for a minute thought that the doctor would give me anything that would actually make you feel so bad!, so I would never have said to the doctor, no. I would have just put them in the bin.

Carla's comments reflected those of some of the other women who were also dissatisfied with clinical services but unable to express these to the relevant professional. Table 20 illustrates the level of satisfaction with professional services reported by the respondents. Comparisons are made by the participants' age, parity and time since diagnosis.

Couple	Ages	Number of children	Time since diagnosis	Medication
Aileen/Alan	35/30	2	14 weeks	Differences between professionals
Barbara/ Bert	32/30	2	17 months	Satisfactory due to good communication
Carla/ Chris	27/29	3	4 months	Unsatisfactory
Dana/ David	36/35	2	18 months	Differences between professionals
Evelyn/ Edward	35/36	3	3 years	Mixed experience depending on location
Frances/Freddy	42/41	2	21 months	Mixed experience depending on location and during second episode
Gina/ George	28/32	2	2 years	Differences between professionals
Hannah/Harold	31/26	1	3 months	0
Irene/ Ian	28/26	2- twins	7 years	Unsatisfactory
Jane/Jason	24/18	1	6 years	Mixed experience depending on location
Karen/Kurt	31/30	1	5 months	Difficult at first then improved
Lena/Len	34/41	2	16 months	Satisfactory due to good communication
Maureen/Mike	30/24	1	3 months	Mixed dependent on location
Nancy/Norman	30/29	1	2 years	Mixed dependent on location
Olive/Oscar	34/35	2	7 weeks	Mixed experience, improved during second episode
Pam/Paul	38/37	2	22 months	Unsatisfactory
Rachel/Richard	40/39	1	7 years	Mixed dependent on location

Table 20 Patterning of experience with professionals

Only two couples expressed their full satisfaction with the services they had received. These were commended due to the good communication between various professionals and the family. Three couples found the management of the woman's illness wholly unsatisfactory. Most couples reported a mixed experience which differed between locations and professional groups. Some women were able to compare their experience over time between a first and subsequent pregnancy. They attributed this improvement to a perceived increased awareness in the profession and their own ability to recognise early symptoms more accurately.

The prescription of medication in particular represents a distinct aspect in the relationship of the respondents with professional workers. They need to be involved in the treatment decision and know which side effects are likely to occur and how to respond when medication fails. The decision making process related to medication is complex and confronts a range of very personal issues for the respondents. These are different for the men and the women but reflect the mixed emotions which this process generates in the couples.

5.3.5.3 Influences on function

The third category (influences on function) describes the issues which impact on the effectiveness of professional services. The respondents comment on the organisational constraints of the service such as lack of time and specialist counselling staff. They also find it difficult to understand some aspects of professional roles. These considerations influence the couples' decisions to seek help from professionals. Workers providing a personalised

service, negotiated with the couple, are valued most. The respondents are aware of the constraints under which some services function. For example Barbara was appreciative of the efforts made by individual practitioners, but also recognised the limits, which affected their ability to offer support. While her comments appeared to view the professional's help favourably, an underlying sense that the help was not fully satisfactory was apparent. Barbara had a good relationship with this helper and might not have felt able to criticise any omissions openly in the interview.

Barbara, postnatal depression after birth of second child, interview 2
she was really helpful and I mean, mind you, she could only do you so much

Other respondents were less forgiving and attributed any problems to the narrow focus of the health service. George for instance noted that the health visiting service seemed to care mainly for mothers and their babies rather than the family. He had casual contact with the family health visitor but considered this to be social rather than professional. Other men like Alan, made similar comments about the perceived limits of other services such as the General Practitioner.

Alan, interview 3
its expertise help you would need, where as a doctor is for your health and not your mental health.

In his understanding, mental health care was different from general medical care and not the responsibility of his general practitioner. These comments represent the group of men who are more likely to manage any problems independently. They are unlikely to seek out health care services, which are

perceived to be irrelevant or unavailable. In contrast, Ian had extensive experience of various healthcare services due to his partner's prolonged illness. Both he and his wife expressed a need to access a variety of treatments but felt that professional services prioritised medication. He highlighted specifically the problems associated with extended waiting times for specialist services such as psychiatry. He felt strongly that a dual approach to treatment should be available, which would combine medication and psychotherapy.

Ian aged 28, often away from home due to work commitments, interview 3
it's a long waiting list or the Doctor thinks it's a year to get in..... it seems like the medication's not a problem.but the other bit should be running concurrently with it at the same pace

Table 21 below highlights the perceived availability of professional services and counselling interventions in particular by age, social group and time since diagnosis. The couples commented on the availability of treatments and how limitations in available resources influenced their choice. Delay in access to counselling services was the main concern for these respondents. They were divided nearly equally in their experience. Nine couples felt that they had a limited choice of services with access to counselling services in particular often delayed or not forthcoming. Couples who commented favourably on this aspect of professional care (8 couples) were able to access other support services beyond a prescription for anti depressants. These differences in perception did not appear to be related to the length of time since diagnosis or the respondents' age or social background but due to differences in the structure and priorities of local services.

Couple	Ages	Occupational classification	Time since diagnosis	Influences
Aileen/Alan	35/30	2	14 weeks	Limited choice of services
Barbara/ Bert	32/30	5	17 months	Choice of services
Carla/ Chris	27/29	3	4 months	Limited choice of services
Dana/ David	36/35	3	18 months	Choice of services
Evelyn/ Edward	35/36	3	3 years	Choice of services
Frances/Freddy	42/41	3	21 months	Limited choice of services
Gina/ George	28/32	3	2 years	Choice of services
Hannah/Harold	31/26	3	3 months	Limited choice of services
Irene/ Ian	28/26	3	7 years	Limited choice of services – delay in access to counselling
Jane/Jason	24/18	unemployed	6 years	Choice of services
Karen/Kurt	31/30	5	5 months	Choice of services
Lena/Len	34/41	1	16 months	Choice of services
Maureen/Mike	30/24	7	3 months	Limited choice of services – delay in access to counselling
Nancy/Norman	30/29	1	2 years	Limited choice of services – delay in access to counselling
Olive/Oscar	34/35	5	7 weeks	Choice of services
Pam/Paul	38/37	2	22 months	Limited choice of services – delay in access to counselling
Rachel/Richard	40/39	1	7 years	Limited choice of services

Table 21 Patterning of perceived availability of services

When services are personalised and perceived to be responsive to the client's needs, then a positive relationship is created between worker and client.

Aileen, interview 1

Not just like a ten minute in seeing the doctor and thrown out the door again I need time to talk no tae just say I have got depression, right here you are there's a prescription that doesnae dae anything for me.

Aileen commented on the positive attributes, which she valued in a professional helper. She appreciated a professional with time to explore her problems and discuss her treatment options. She did not want to feel that she was 'bothering' the professional with her personal concerns.

Table 22 illustrates the patterning of responses for this network for each subcategory by age and social class of the respondents. Responses are distributed across age, social background and time since diagnosis. The personal attributes of the helper are one of a range of influences on the function of the professional. Workers are often perceived to have limited scope in their practice or offer services to a narrowly defined client group. This can result in a perception that services are not relevant or offer only a limited choice.

Couple	Ages	Occupational classification	Time since diagnosis	Activities	Medication	Influences
Aileen/Alan	35/30	2	14 weeks	*	*	*
Barbara/ Bert	32/30	5	17 months	*	*	*
Carla/ Chris	27/29	3	4 months	*	*	*
Dana/ David	36/35	3	18 months	*	*	*
Evelyn/ Edward	35/36	3	3 years	*	*	*
Frances/Freddy	42/41	3	21 months	*	*	*
Gina/ George	28/32	3	2 years	*	*	*
Hannah/Harold	31/26	3	3 months	*	0	*
Irene/ Ian	28/26	3	7 years	*	*	*
Jane/Jason	24/18	unemployed	6 years	*	*	*
Karen/Kurt	31/30	5	5 months	*	*	*
Lena/Len	34/41	1	16 months	*	*	*
Maureen/Mike	30/24	7	3 months	*	*	*
Nancy/Norman	30/29	1	2 years	*	*	*
Olive/Oscar	34/35	5	7 weeks	*	*	*
Pam/Paul	38/37	2	22 months	*	*	*
Rachel/Richard	40/39	1	7 years	*	*	*

Table 22 Patterning of responses for network: professionals

* indicates that this issue was raised by the partners during at least one of the interviews

0 indicates that this issue was not discussed by the respondents during the interviews

Personalised services, which are judged to be responsive to need, are valued. Those with perceived time constraints are more likely to be rejected. Most respondents comment on the difficulties they experience to understand mental illness and the available treatment options. They expect professionals to be able to explain these complex processes clearly and allocate sufficient time to do so. If done effectively, this can influence compliance and recovery.

5.3.6 Solutions

This category network relates to the different factors which affect the couples' ability to find solutions and influence recovery. The subcategories identified here are: the couple's personal resources, the helper's attitudes, the services available and the strategies to manage the illness. The personal resources, which the respondents bring to the management of the illness, relate closely to the strategies employed by them. Women need to be able to share their experience and receive reassurance from a sympathetic listener. Compliance with medication is an important personal resource to aid recovery. The helper's response to the illness is significant. It affects how the couple manage the illness and request help. Women need to feel respected but also ready to accept help. The couples consider a range of solutions based on their understanding of various services. A number of strategies are utilised to manage the illness. Some of these can be beneficial to recovery, while others can act as potential barriers to help.

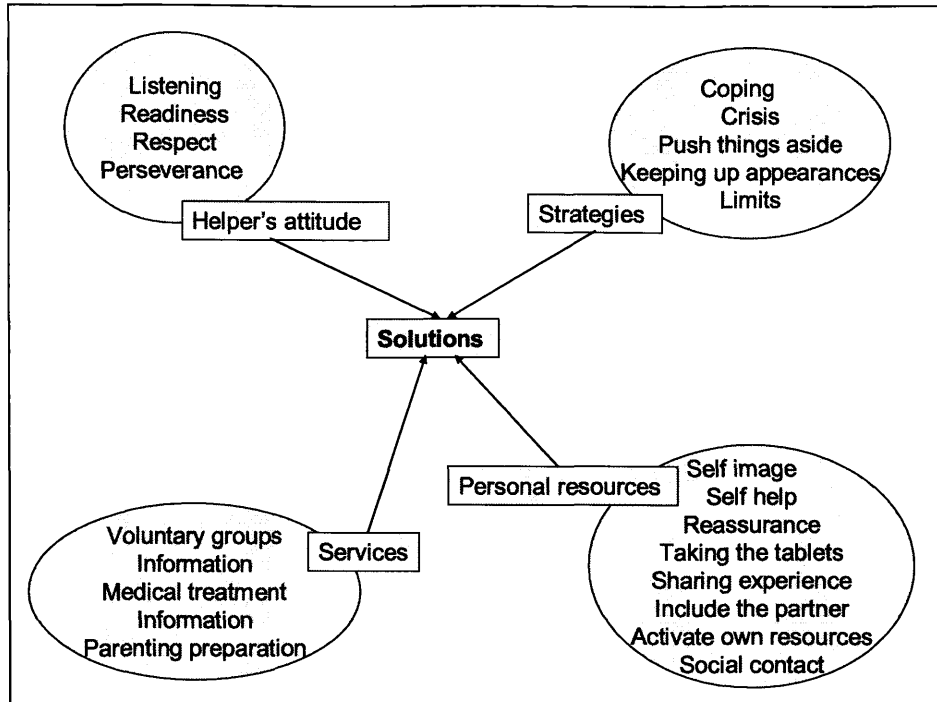


Figure 10 Network: solutions

5.3.6.1 Personal resources

Existing coping mechanisms and the couples' response to the illness are some of the factors included in the first subcategory (personal resources). How the partners share their experience, include the partner and comply with medication affects their ability to seek solutions for their difficulties. The woman's self-image, a desire to identify as 'not a bad person', helps the woman to manage her illness. The personal resources identified in this network differ from the subcategory 'resources' described in the category 'access' earlier. The latter relate to the resources available to the couple from the various helpers such as family and friends. The subcategory 'personal resources' described here in the 'solutions' network specifically explores the personal resources of the woman and the couple themselves.

Aileen summed up the importance of the couple relationship. This couple had experienced significant challenges to their relationship prior to Aileen's depression and frequently reaffirmed their commitment during the interviews. Their mutual bond was very important to them and expressed by various maintenance activities.

Aileen aged 30, postnatal depression with second child, interview 1
we just know that we have a good strong relationship and we always tell one another that we love one another, quite open about that, how we feel towards each other.

The willingness of the partner to try and understand the woman's experience is equally important. For Hannah and Harold, this was a learning process. Hannah suggested that Harold's willingness to try to understand her actions strengthened the relationship significantly.

Hannah, 21 months since diagnosis, interview 2
he learned to understand..... why I was reacting in certain ways and it definitely helped – it made us stronger again

For some of the couples this process can be difficult. Ian tried to understand Irene's emotional difficulties but failed to do so to Irene's satisfaction. This couple had to respond to a number of significant difficulties in their personal lives. They had managed Irene's severe mental distress and the demands of two very challenging young children, while feeling socially isolated and distanced from any service provision. Despite these considerable challenges, both partners continued with the relationship.

Although postnatal depression makes considerable demands on the couple relationship, the condition is perceived to be temporary. Deeply embedded

attitudes based on their personal history and approaches to life sustain the couple through this period of stress. George summarised the attitude of the respondents. His personal values of commitment and perseverance gave him the inner strength to manage the challenges imposed on him.

George, interview 3

sometimes there was no quality in the relationship and at other times I was, you know I'd think about it and say "Oh, dinnae be so stupid. There's too much to lose" you've got to try wee bit harder. It's too easy just to walk away."

At time, the respondents can also feel helpless and unable to find such inner strength. Evelyn's low mood affected her ability to summon her personal resources. She knew that she should help herself, but felt unable to do so. Her partner's concern and encouragement to seek help were therefore crucial for her. Evelyn and Edward relied on each other for emotional support but also felt vulnerable.

Evelyn, one year until diagnosis of depression was made, interview 1

I had nothing to compare it with and when he spotted it and made me promise to go to the doctor, I thought "well at least now I can get help"

All women had received or were receiving medication to treat their postnatal depression. The decision to take the tablets is often complex and the result of a lengthy process of deliberation. Evelyn described her doubts and the perception of personal failure, which a prescription for medication implied for her. Her pragmatic decision to accept the medication eventually became part of her personal solution.

Evelyn, interview 2

I felt I was a failure, because I had to take pills. I eventually went back and said, I'm going to have to. I'm going to have to.

Medication is perceived to be part of the solution but can raise issues of compliance. Carla felt sufficiently unwell to doubt her decision to start on medication. She was determined to overcome her reservations and continue to 'take the tablets'. Compliance with medication is perceived to be an essential component to aid recovery.

Carla, interview 2

I was so relieved that I had continued to take the tablets because if I hadn't taken the tablets I would be in a worse state of mind than I am, definitely.

Personal resources and values influence the women's and the couples' response to the illness. The couples have a sense that their relationship is valuable and worth saving. This commitment helps them to persevere with their relationship. Often the male partner is perceived to be the stronger, making considerable efforts to maintain the relationship despite personal doubts and challenges to his own emotional health. Attitudes to the use of medication and compliance with medical treatment are additional personal considerations and affect solutions to the illness.

5.3.6.2 Services

The third subcategory 'services' relates to the types of support mechanisms available. These range from information and parenting preparation to the availability of medical treatment and help from a number of different sources of support. The respondents judge services on their quality of information, accessibility and timeliness. Different types of treatment are perceived to fulfil

different functions: medication treats the symptoms of the illness; psychological therapies explore the underlying causes of the woman's emotional distress. Support groups are mainly relevant for the female respondents, while the men have reservations about sharing their experiences in such a setting. Alan for instance suggested that he would have appreciated access to a combination of information sources. These would have included some leaflets but mainly personalised information from a knowledgeable individual. For this couple, information leaflets were seen to be easily discarded and therefore less relevant. Information gained during contact with a healthcare professional was felt to have more impact, raise awareness and aid early recognition.

Alan, interview 1

leaflets sometimes can be read once and then just discarded. Maybe if somebody had ... actually sat down and said look out for this and look out for that, I think that would probably stay in your mind more than just a leaflet

Chris shared this need for personal information. His sister, who had suffered from postnatal depression, was the main source of information for him. He appreciated the personalised contact, which helped him find solutions to his specific problems. For the men this search for information was driven by a desire to be able to respond effectively to their partner's illness.

The need for information is not restricted to the immediate management of postnatal depression but to parenting activities as a whole. David commented on the presentation of childbirth and motherhood in parent craft classes. Both he and Dana had attended these prior to the birth of their child. The

expectations generated by the 'rosy picture' of parenthood presented there conflicted with the reality of the couple's experience. This had left them feeling helpless and confused.

David, interview 1

I think it would be, it would be a fine line I think between telling the truth or what could be the truth and not distressing people and frighten them.... 952-958 one of the things I have noticed about the parent craft classes is, they do paint a very rosy picture of what childbirth is going to be.....when things don't go exactly to plan.... you don't have always people to turn to talk about it.

Parents need to be prepared for the realities of parenthood, but presented with this information sensitively. David's comments highlight the additional requirements of parents experiencing postnatal depression.

In addition Irene and Ian pointed out the importance of a dual approach to treatment. This couple had experienced a range of treatments over the course of two years. They had been treated by a number of different professionals but felt that these interventions had been disjointed, lacking a coordinated approach. Their comments underlined the need for a treatment approach, combining medication and psychological interventions.

Other couples like Aileen and Alan shared this view. They felt that medication would treat the symptoms, while psychological therapies would address the causes of the illness. They classed medication as a short-term treatment, readily available through local health services. The latter was seen to provide long term benefits but was often rationed and more difficult to obtain.

Alan, interview 1

drugs would just really be like a short term fix whereas ... counselling, get to the root of the problem..... they probably are fobbing people off with drugs just to empty the surgeries without doing anything about the problem.

These perceived limitations of the health care provision can prompt the search for other sources of support. The women described the benefits of support groups to them but their partners were less enthusiastic. Karen felt that her social isolation contributed to her depression. The preparations for her outing to a local mothers' group were stressful, but outweighed by the benefits of social contact with other mothers.

Karen, interview 2

I think it was more isolation. So for going to the baby massage class was exactly what I needed. as much as I would say it was a lot of stress to get the baby ready and get myself ready and be out the door for a certain time. For me it was my highlight of the week and it gave me something to look forward to.

Alan preferred a more individual setting to discuss his questions. He speculated that a support group may not have been beneficial for Aileen. His views were exceptional. The other men acknowledged the support, which their partners gained from attendance at a group.

Alan, interview 3

I don't know if I would talk openly around other couples. I think if there was somebody sat down trying to tell us about things, I would listen to more ... I don't think I'd talk in a group situation.

Men and women express different attitudes in relation to group attendance. The women are often very positive about the benefits of group support; their partners are more ambiguous.

All couples comment on the range and types of services available to them, access issues and the perceived benefits of the different treatments. The dissemination of information about postnatal depression is of interest to the men who express a desire to be informed about the condition. They do recognise that it could be difficult to balance the need for this information with a very negative portrayal of parenthood. A combined approach to treatment in the form of medication and psychological therapies is desirable. Men and women differ in their attitude to group support.

5.3.6.3 Helper's attitude

The second subcategory 'helper's attitudes' identifies actions and qualities which facilitate help and support recovery. The respondents value a willingness to help but can test this by their reluctance to accept the support offered. An attitude of respect and an ability to listen ensures that the woman feels her concerns are acknowledged and valued. These attitudes rather than the professional qualification or training of the potential helper are important for effective support. Karen for instance commented positively on her mother's ability to understand her daughter's problems. Her mother became her main helper. Although she lived a considerable distance away, Karen appreciated her mother's emotional support and empathetic understanding.

Karen, interview 2

I just couldn't cope with other people in my home apart from my mum. She kind of understood, understands me a bit more.

Not all respondents found an empathetic response from their family. Olive contrasted the different attributes of her parents. Her father had had

experience of postnatal depression when his own sister had suffered from the illness as a young woman. This had provided a close bond between him and Olive after the birth of her first child. Olive had relied solely on his support during her own illness at the time. I met the couple after the birth of their second child and the death of Olive's father. A very different support network had developed and included a range of other family members. Olive's own mother was on the periphery of this network, unable to fully understand her daughter's difficulties.

Olive aged 35, postnatal depression after birth of both children, interview 1
it was my dad that helped me so much my mum's still here..... but she doesn't understand, does she? she just doesn't want knowshe's no understanding it very well at all is she?

The helper's perceived attitude can affect their level of involvement with the young family. This couple, like most of the other respondents, assessed the attitude of their potential helper before they accepted help. In addition they needed to be ready to accept this support. For instance once Olive was able to give her mother-in-law permission to help did she receive help with childcare and practical tasks. Olive reflected on her previous attitude and how her views had developed following a change in her circumstances. With hindsight she re-evaluated the potential help she might have received previously.

Olive, seven weeks since diagnosis of depression after birth of second child, interview 1
I think her change in attitude is because I'm allowing her to help this time and I'm sure if I'd allowed her to help the last time she would have

For Olive and her family the experience of postnatal depression and the help available during two episodes of postnatal depression were very different. The couple attributed this mainly to their own changes in attitude, their readiness to accept help, but also an increased awareness of the illness based on their previous experience.

This couple had received help from a range of sources due to a change in their own attitude but also that of their helpers. For others this was impossible to achieve. David for instance had found it difficult to ask for help. On reflection he recognised that he could have benefited from an empathetic listener. Only a very persistent helper would have been able to overcome David's internal barriers and encourage him to be open about his feelings. He would have accessed help but needed the helper to take the initiative. In this way David placed the responsibility to offer help on the helper. This attribution provided a justification for his action at the time but possibly also allowed him to remain emotionally distant.

David, interview 1

if somebody had said, how are you? how is this affecting you, then that would have been easier for me to open up and talk to them about it. Whereas, yes I would have struggled to go and say to somebody: I'm finding this stressful, this is really hard!

While most of the fathers express similar sentiments, some of the men, contradicted this attitude. Oscar for instance felt strongly that an interest in the father's emotional health could be perceived as inappropriate. He recalled an encounter with a professional at the time of his wife's first illness approximately eight years previously. This person appeared to the couple to

be more interested in Oscar's rather than Olive's well being. Oscar felt that the focus of attention and care should have been on Olive who was acutely distressed and required immediate attention at the time.

Oscar aged 34, joiner, interview 1

he was no interested in you whatsoever and then as we walked to the door he says 'and are you okay are you needing anything, you sleeping okay?' but how could you not say that to her?

The men state that their main concern focuses on the care of their partner and her need for treatment. If help is available for the men it needs to be offered at the right time and with sensitivity. The helper should be able to probe gently but persistently.

The qualities of the potential helper, which are valued most, are independent of their profession or their qualifications. The helper should be interested, understand the problem and help the person feel comfortable enough to share their feelings. The helper's attitude, the couple's perception and their readiness to accept help are all considered by the couples when they seek solutions to their difficulties. Sometimes even well meant help, can be perceived to be inappropriate or untimely. Any intervention is judged against the quality of the relationship with the helper, feelings of trust and safety.

5.3.6.4 Strategies

The strategies (fourth subcategory), which the partners utilise to manage the illness, are a further consideration in this category 'solutions'. The respondents, in particular the men, comment on their tendency to deal with

their concerns by 'pushing things aside'. A crisis and an awareness of the limits of the help available can affect the response to the illness. The women adopt a strategy of 'keeping up appearances' to present a functioning image to those around them. This network summarises a range of factors, which influence the couples' search for solutions and their help seeking. Components from this network inform the core category of this study proposed in chapter 7.

George summarised the men's perspective. He presented a positive image at his work and returned to his domestic concerns at the end of his working day. George felt he needed to create distance between home and work. While this strategy was useful, it was also a difficult, and frequently stressful, balancing act to maintain.

George, interview 3

I'm one of these folk who kind of just put things to the back of my brain until I'm facing them again and then go back and then I will. Like I would leave here fed up and getting crabbit and then going to my work and be all happy go lucky and cracking jokes and just having a laugh leaving your problems at home and come home again

In contrast, Freddy preferred to draw on his personal resources. He took a systematic, problem solving approach to manage personal challenges. He relied on self-sufficiency to solve his personal problems.

Freddy, interview 3

I never talk; I never talk about anything, do I? I've always sorted out my own problems. you identify what your problem is to find out what your options are – work out what the best way to go is

Such a self-reliant attitude could change with time and did not necessarily preclude the partners from discussing their problems with each other. Jane and Jason for instance gradually realised that they would need to seek help from others outside the immediate family circle. Jason became aware that Jane reacted differently to minor irritations in the home. His concerns eventually triggered discussion between the partners and an approach to their local general practitioner.

Jason aged 24, living a distance away from own family, interview 1

I found as weeks went on that she were getting upset for no reason and crying. So we decided there were definitely something wrong and she has to see the Doctor.

Jason's comment reflected the sense of helplessness which prompted the couples' search for professional help. Karen's social and geographical isolation limited her access to support systems. To avoid a further deterioration in her condition, Karen sought help from her general practitioner.

Karen, interview 2

it was the best thing to do would be to go to the Doctor's and before it got any worse as well." I'll need to go to the Doctor's and get help medicine-wise because there aren't the other sources of help around in my situation."

Karen's actions contrasted with those of the other women who felt the need to keep up the appearance of a functioning individual. Frances called this the 'earring and lipstick conspiracy'. She paid particular attention to her appearance to hide her feelings of depression and present herself as competent to those around her.

Frances, interview 1

I call it the 'earring and lipstick conspiracy'. put on your earrings, lipstick and look kind of respectable, so, andI think they just thought "oh she's coping".

Lena adopted a similar strategy to protect her from outside challenges at a time of particular vulnerability. Lena felt that others perceived her to be an independent person, able to manage personal challenges effectively. Prior to the birth of her children, she had been a successful businesswoman, in charge of herself and those working for her. She used the image of a 'protective shell' to describe her need for safety, armour against a hostile world. The interview provided an opportunity for Lena to make sense of her experience but also to express her sense of vulnerability through the use of imagery.

Lena aged 41, childminder, previously had managed her own business, interview 2

I'm wondering whether, you know, if I'm kind of putting this bubble round me and this is the protective shell,

Table 23 illustrates the patterning of responses for this network for each subcategory by age and social class of the respondents. Responses are distributed across age and social background. Only two couples did not specifically mention the importance of the helper's attitude as part of their search for solutions. These couples were from different social backgrounds and also had different support network available to them. Four couples did not explore in detail the strategies which had helped them to resolve their difficulties. This difference is more likely to reflect the focus of the specific interviews with these respondents rather than their social or age differences.

Couple	Ages	Occupational classification	Personal resources	Services	Helper's attitude	Strategies
Aileen/Alan	35/30	2	*	*	*	*
Barbara/ Bert	32/30	5	*	*	*	*
Carla/ Chris	27/29	3	*	*	*	0
Dana/ David	36/35	3	*	*	*	*
Evelyn/ Edward	35/36	3	*	*	*	0
Frances/Freddy	42/41	3	*	*	*	*
Gina/ George	28/32	3	*	*	0	*
Hannah/Harold	31/26	3	*	*	*	0
Irene/ Ian	28/26	3	0	*	*	0
Jane/Jason	24/18	unemployed	*	*	*	*
Karen/Kurt	31/30	5	*	*	*	*
Lena/Len	34/41	1	*	*	0	*
Maureen/Mike	30/24	7	*	*	*	*
Nancy/Norman	30/29	1	*	*	*	*
Olive/Oscar	34/35	5	*	*	*	*
Pam/Paul	38/37	2	*	*	*	*
Rachel/Richard	40/39	1	*	*	*	*

Table 23 Patterning of responses for network: solutions

* indicates that this issue was raised by the partners during at least one of the interviews

0 indicates that this issue was not discussed by the respondents during the interviews

The respondents use a variety of management strategies to overcome the challenge of postnatal depression. The men push the emotional difficulties created by their partner's illness aside, often distancing their personal from their wider social and working lives. The couples gradually realise that they need outside help to respond to the deterioration of the relationship. Keeping up the appearance of being in control and coping is an important strategy for the women. This allows them to present themselves as competent to others and manage their feelings of vulnerability.

5.3.7 Help seeking

This network relates to an overarching theme, which illustrates the need of the woman to be believed and the condition to be recognised by others. Unless the woman acknowledges her need and is believed by those around her, is she able to access help. This network is closely linked to the network 'emotional health' above, which provides the background to the couples' help seeking. The respondents consider four groups of factors when they seek help: their relationship with potential helpers, services, access to them and a number of other considerations. Some are specific to the couples and their potential helpers while others, such as services and the conditions to access them, are outside their control.

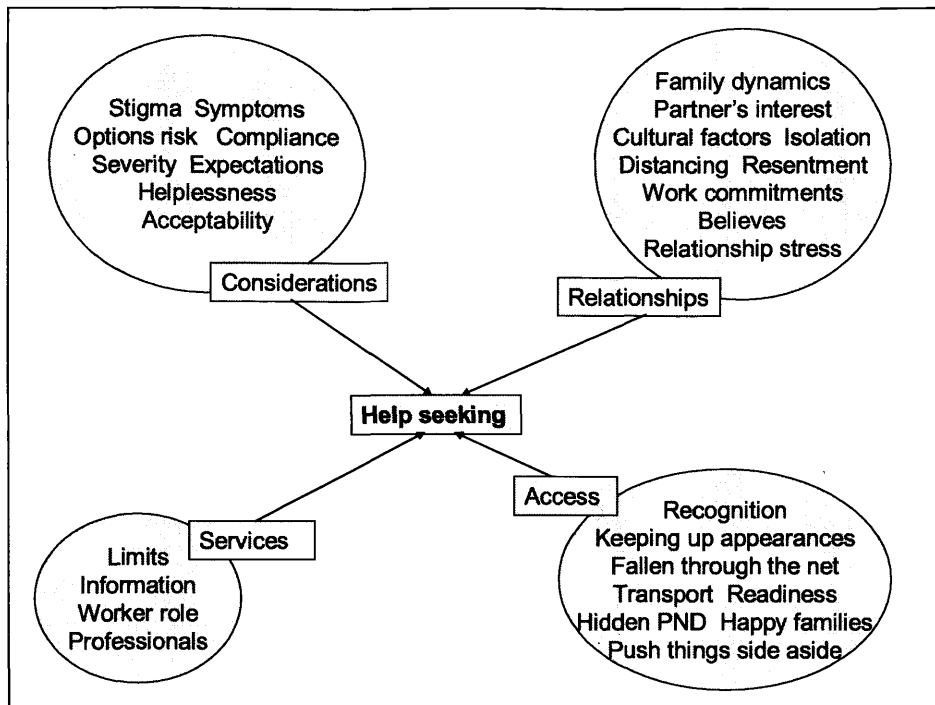


Figure 11 Network: help seeking

5.3.7.1 Relationships

Various aspects of the relationship (first subcategory) with the potential helper are important for both the individual and the couple. Family dynamics and the specific relationship between the partners in particular play an important role. The partner's attitude, either his active interest or his distance, is important. Relationship stresses and feelings of isolation are closely linked to these factors. The men may cite work commitments as a reason for a lack of engagement. This can cause resentment and further stress in the relationship. This particular cultural understanding of gender roles is one of many aspects which influences the partners' relationship and level of engagement. The woman needs to be believed by her partner and others to access help.

Karen for instance commented on the tension between Kurt's work commitments and her own needs. The demands of his new business contributed to the stress in the couple's relationship. Karen felt unable to raise these concerns with Kurt. Her need for support from him conflicted with her wish to keep any strain to a minimum. Kurt was already stressed in his working life and did not need the additional burden of demands from his young family. Karen's comments reflected a potential tension in the couple relationship, which she might not have been able to fully express in the interview situation. Citing Ken's work commitments justified his lack of involvement but also suggested that he had not been available to help as much as she had hoped for.

Karen, interview 2

I couldn't say too much about that because obviously it then made him feel bad cos he wanted to be here but he's got to work. He's got to put food on the table.so it was kind of a bit tricky to try and say how I felt without kind of putting it all on to him which wasn't fair

This desire to protect the partner from additional stress has the potential to create a sense of distance between the partners. Aileen for instance distinguished between the professional helpers she utilised and her expectations of help from her partner, Alan. Only a significant deterioration in her emotional health would have prompted her to share her deeper feelings with him. This approach worked for this couple and was acceptable to both of them. For other couples like Karen and Kurt it created a sense of isolation and distance.

Aileen, interview 4

we were quite happy in our relationship. If I was suffering bad from depression then I would say "you need to help me" but because I was getting help with my Counsellor and the Health Visitor, that was enough for me.

Family dynamics influence not only the couple relationship but also the response to other potential helpers. Aileen was pragmatic about her expectations of her wider family. She did not receive appropriate support from her family previously and did not have any expectations. She managed her difficulties independently without recourse to others.

Aileen, interview 4

they weren't there for me and I done it myself... So they're not supportive.

In contrast, Carla expected support from her family and valued their contribution. She expected her helpers to listen rather than give advice and selected them accordingly.

Carla, interview 2

you speak to your family and they give you their point of view. You don't always necessarily want their point of view. You just want them to listen to you and tell you

Unfulfilled expectations can contribute to feelings of resentment and isolation in the relationship. The woman expects her partner to show interest in her difficulties. Ian and Irene experienced considerable stress in their relationship since Irene felt frustrated by Ian's perceived lack of interest. Ian's attempts to understand her difficulties were unsuccessful and did not alleviate the partners' sense of isolation from each other. Irene's ongoing dissatisfaction with the relationship was reflected in her use of the present tense in the comment below. The appeared to use the interviews as an opportunity to

present her perspective to a sympathetic listener, possibly perceived to be more sympathetic than her partner.

Irene, interview 2

he doesn't seem interested. So I keep it to myself, which I think makes it worse. I've tried to explain a few times. He doesn't seem interested

This sense of frustration can extend to other helpers outside the couple relationship. Frances' repeated visits to her local medical centre after the birth of her first child did not meet her expectations of help. She felt that her own attempts to present herself as 'coping' may have delayed her diagnosis. This was exacerbated by a sense of disbelief and rejection from the professionals.

Frances, interview 1

when I was going to the doctor and they were saying "Oh no, everything feels likes this. Having a baby is a change of life". maybe ... it didn't look like I was struggling enough. why nobody would believe me

The relationship with the potential helper is significant and can influence help seeking from the family and professionals outside the immediate network. Feelings of distance and isolation can be created by perceived unhelpful responses such as a lack of understanding, inappropriate advice giving and a failure to believe the woman.

5.3.7.2 Considerations

A number of considerations (second subcategory) influence the couples' decision to seek help and accept offers of treatment. These relate to their feelings around postnatal depression, in particular helplessness and the

potential stigma of mental illness. The respondents commented on their expectations of parenthood and the acceptability of the treatment options available. Both Aileen and Barbara highlighted the difficulties inherent in a diagnosis of mental illness. For Aileen, this stigma was more significant when she was unwell. She felt more able to speak about her difficulties once she began to recover. When I spoke to her at the time of the second couple interview, she had been able to return to work and was meeting customers from a range of backgrounds. She commented on her ability to speak to them about her own illness and share her experience.

Alan, interview 2

people with depression and that tend no to like talking about it even to family. Most people don't, you know. There's kind of a stigma attached to it

Barbara had similar reservations, which focussed particularly on the stigma of mental illness in a small community. This couple were well known in the village and felt vulnerable to local gossip. Throughout her illness Barbara found it difficult to interact with casual acquaintances in the village. Her main sources of support were a few selected close family members, friends and professionals.

Barbara, interview 2

I didn't want to tell a lot of people either what was wrong with me and plus I don't want it leaking out, you know, in a small village like that.

Lena summarised the mixed emotions and range of considerations, which influenced her decision to seek help. The potential stigma of a diagnosis of postnatal depression conflicted with her desire to meet her expectations of parenthood. Her image of parenthood as a 'magical' time, special for her and

her children acted as the driving force for her to seek help for her difficulties. She expected parenthood to be a positive event but feared the treatment options available to help her achieve this goal. She overcame her reservations out of concern for the welfare of her children and her family and described her subsequent relief.

Lena, postnatal depression after the birth of her second child, 16 months after diagnosis, interview 2

I didn't really want to go on the medication either, and that having a stigma attached to it andthat I was actually, you know, needing to sort myself out for the whole family's sake really I felt that I'd actually done it for the kids as much for myself really so that, you know, it would be as I'd imagined it would be having children. A bit more magical than hating every minute of it.

Considerations of the stigma of mental illness and concern about the response of others are part of the decision to seek help. The importance ascribed to these factors is directly related to the degree of severity of the illness. As the woman recovers, she is more able to share her feelings and be open about the emotional difficulties experienced. The fear that these expectations can not be fulfilled can influence the decision to seek help and overcome reservation about the treatment on offer.

5.3.7.3 Access

The third subcategory, access to the help available, relates to internal- and external family systems. The immediate members of the family considered to be part of the internal family system include the couple and their child as well as close relatives and friends. Others not included in this group are part of the external system. These are more distant members of the family and friends as well as professionals and the wider community. Each couple

includes different people in its internal and external system. Membership is defined by family relationships and the level of help available from the various sources. Access to help is influenced by the desire to 'keep up appearances' and the couple's level of readiness to ask for support. The couples compare their own experience with that of other families. A perception that others are more successful at the task of parenting can act as a barrier to help. The timely recognition of postnatal depression is important but is affected by the perception of postnatal depression as a hidden illness. Apart from emotional barriers to help, the practicalities of access need to be considered.

For Carla it was important that she presented herself to her immediate family as effective and functioning. This was less of an issue in relation to her interaction with others outside the immediate family. A special effort was necessary to convince her family. Her sister was not able to recognise Carla's difficulties and attributed her symptoms falsely. This deprived Carla of a potential source of help.

Carla, teacher, rural environment, close contact with extended family, interview 2
I'm not particularly bothered about what outsiders think but with your family you have got to put on a face so that they're not aware of how you are actually feeling, aye, because to start with my sister thought that this was all just a ploy so as that I could get off my work on the sick.

She later returned to the considerable effort, which was required to maintain this functioning image, to 'keep up the face'. Carla was relieved when she was eventually able to disclose to her family and talk openly about her difficulties.

Carla, interview 2

to keep up the face all the time.... It's so exhausting. At least then, when you've admitted to people, you can start to feel a wee bit better about it

Hannah found such attitudes particularly challenging, when she met other women with babies of a similar age. Their positive stories, sometimes told despite evidence to the contrary, added to her distress and led to her to withdraw from a potential source of peer support. She experienced significant internal emotional conflict which caused her additional stress.

Hannah, rural environment, first child, interview 2

I didn't want to be involved, you know, with other people, hearing how fantastic they were getting on with their babies and how wonderful life was soI felt it was best just to stay away and do my own thing

Postnatal depression continues to be perceived as a hidden illness. Barbara was able to access useful support from her sister- in-law but felt she had to be selective in her choice of helper. She was concerned that it would be difficult to guard her privacy in her small village. As a result Barbara was very careful in her choice of confidante.

Barbara, rural environment, previous partner continued to live in local village, interview 2

the ones that I did tell were really good and, you know, but I sort of felt that I had to choose who I told

The personal attitudes of the person and the potential helper are significant factors to access help. In addition some practical consideration can also impact on this process. Carla for instance had been given contact details for a support group from her local doctor's surgery. She found it difficult to make the initial telephone contact with this group and eventually gave up,

discarding the information. Carla was vocal and had previously overcome some significant personal difficulties competently and confidently. She was surprised and frustrated that she had been unable to make a simple telephone call.

Carla, teacher, interview 2

You are sitting there with the telephone in your hand and you're shaking and you're going "I cannae, I cannae" and then you end up just ripping the bit paper up and putting it in the bin

Some relatively minor issues can take on a new significance for the depressed woman. Karen's feelings of isolation were exacerbated by her inability to drive the family car. In an attempt to help, Kurt tried to encourage Karen to go on short walks but found it difficult to motivate her. The location of their little cottage at the end of narrow country lane became a significant issue for her.

Kurt aged 31, gardener, often working long hours, interview 4

That's what she was needing because she wouldn't go. If we even went for a walk, for instance, she wouldn't do that.

During an earlier stage of the interview, Karen confirmed this. Gaining her driving licence and the ability to be mobile became one of the most significant contributors to her recovery. It helped to reduce her feelings of isolation and maintain contact with other mothers.

Access to potential help can be compromised by the woman's personal attitude and a desire to present a functioning image to those closest to her. When faced with images of the happy parenthood of other mothers, the

woman is likely to withdraw from a potential source of peer support rather than maintain the considerable effort to present a false image to others. She selects her helper carefully to avoid compromising her privacy. This can potentially limit her access to the full range of help available. Tasks perceived as minor, requiring little effort, can become insurmountable and present barriers to access.

5.3.7.4 Services

Finally, the services available to the respondents (fourth subcategory) are significant factors. An understanding of the roles of different workers informs the decision to access help. Information is available from various agencies, but needs to be presented in a format accessible to the respondents. The couples are aware of the constraints of the services they are in contact with. Time, availability and personal relationships are important considerations when they access these services. Jane and Jason for instance felt let down by different services and their lack of interest in this young couples' difficulties. They had experienced different attitudes from service providers in two areas and contrasted those received at their first address with those at their current home. They judged a family oriented service more favourably than one focussing on one individual.

Jane, aged 18, and Jason, aged 24, had moved to live closer to her family, interview 1
Jason: my local Health Visitor's very helpful as well. She seems to care equally about you and your baby. Not just the baby.

Jane:..... they offered me no help at all and even my Health Visitor wasn't interested was she? Only interested in baby.

Prior contact with, and knowledge of, the worker aids communication based on mutual trust and an understanding of the professional's role. Barbara had known her health visitor for a number of years since the birth of her first son. This personal knowledge allowed her to relate to the worker and trust her with her emotional difficulties. Bert, her partner, was more concerned to obtain relevant information from different professionals, which could be applied to his personal situation. He valued the contact with the community psychiatric nurse, an informed outsider able to clarify any questions. Bert met various workers as they visited his wife. Although not directly involved in these visits, he appreciated the opportunity to understand his partner's illness better.

Bert aged 32, own family lived close, interview 1
gave us literature to read about it, which did make a difference to try and understand what she was going through and to try and help her. But I the fact that he was somebody on the outside looking sometimes, when you are in the situation, you can't see the wood for the trees.

Direct contact with a helper is valued but often not available to the men. David felt frustrated that he lacked appropriate knowledge to help Dana more effectively. It was only with hindsight that he recognised the potential benefits of advice and guidance. At the time, he felt helpless and unable to access relevant information.

David, interview 3
at the time I just felt so frustrated I didn't know what to do and I didn't know who to go and see

Lena described the factors, which helped her benefit from contact with a professional. The consultation with her general practitioner was short, but felt to be beneficial. Prior communication between the health visitor and general practitioner had prepared the meeting. Her general practitioner's approachable personal style and listening interest helped reduce Lena's anxieties. In addition her concerns were dealt with without prejudice in an open and accepting manner.

Lena, interview 2

obviously in sort of general surgery and you don't have that much time andshe was kind of briefed if you like beforehand but she just listening and understanding and gentle she was seeing me as if I was a new mum and she didn't have any preconceived ideas about me as a person

The role and attitude of the professional are important to the respondents. Most of the services are perceived to focus on the woman, rather than the family. This can present problems particularly for the man who can feel excluded from information and on the periphery of health care. Some men appreciate direct contact with health care professionals but often feel unable to seek out the relevant information. Others utilise the information conveyed to them through their partner. Encounters with health care professionals can be enhanced when they are prepared in advance to maximise the time available and are based on trust and an understanding attitude from the worker.

Table 24 illustrates the patterning of responses for this network for each subcategory by age and social class of the respondents. The distribution of responses reflects the significance of this category to the respondents. All

participants discussed at least three if not four aspects of this network when they considered their efforts to obtain help from those around them.

The network 'help seeking' contains four subcategories: relationships, the considerations that influence the respondents' decision to seek help, access issues and the characteristics of the available services. All are interrelated and often overlap with each other and with other networks.

As the analysis progressed, elements from the networks described above were incorporated into the core category and related processes proposed in this thesis. These did not emerge until the concepts had been analysed further, links had been explored and a number of hypotheses had been developed. As part of this process, various aspects of the above categories were examined in more detail. In particular the network 'solutions and access' was explored further due to its relevance to the key areas of interest for this study: the impact of postnatal depression on the couple relationship and related support issues. All networks further informed the second deductive stage of the analysis and contributed to the formation of the process theories proposed.

Couple	Ages	Occupational classification	Relationships	Considerations	Access	Services
Aileen/Alan	35/30	2	*	*	*	*
Barbara/ Bert	32/30	5	*	*	*	*
Carla/ Chris	27/29	3	*	*	*	*
Dana/ David	36/35	3	*	*	0	*
Evelyn/ Edward	35/36	3	0	*	*	*
Frances/Freddy	42/41	3	*	*	*	*
Gina/ George	28/32	3	*	*	*	*
Hannah/Harold	31/26	3	0	*	*	*
Irene/ Ian	28/26	3	*	*	0	*
Jane/Jason	24/18	unemployed	*	*	*	*
Karen/Kurt	31/30	5	*	*	*	*
Lena/Len	34/41	1	*	*	*	*
Maureen/Mike	30/24	7	*	*	*	*
Nancy/Norman	30/29	1	*	*	*	*
Olive/Oscar	34/35	5	*	*	*	0
Pam/Paul	38/37	2	*	*	*	*
Rachel/Richard	40/39	1	*	0	0	*

Table 24 Patterning of responses for network: help seeking

* indicates that this issue was raised by the partners during at least one of the interviews

0 indicates that this issue was not discussed by the respondents during the interviews

5.3.8 Summary of respondent narratives

During subsequent interviews with individual respondents, the couples' narratives were explored in more detail. The network links proposed above were checked with the respondents. Also any additional questions arising from the early analysis were clarified. The following summary narratives identify the key issues, which arose from the first stage of the analysis and functioned as tentative hypotheses for testing in the second stage.

Both the partners cope differently with the situation in the home, which is often one of conflict. An inability to communicate with each other can generate feelings of anger and frustration with the other partner. The men interpret the loss of physical intimacy as rejection by the partner. The decision to keep the problem in the family reflects the sense of stigma surrounding mental illness. This can increase the feeling of isolation experienced by the respondents. The couples cite a number of reasons why they have decided to stay together. Most couples consider that mutual care is an important part of a functioning relationship. Some couples remain together primarily to care for their children. Others feel that their difficulties are likely to resolve with time and patience. The partners feel that support given to one partner in the past should be reciprocated to help the partner currently in need. The emotional challenges posed by postnatal depression and adjustment to new parenthood are a central concern for all respondents.

People and their activities are at the core of support for the couples. They fall into two categories: lay people and professional workers. Lay people are

family members such as grandparents, female relations and friends. For some men, a male buddy can act as confidante under exceptional circumstances. Lay persons support the couple through understanding and encouragement. Experiences with others are shared and companionship sought through this network. They have time to develop a relationship with the person, reassure and are available, when needed. Practical help and help with childcare are provided mainly by these lay sources. Lay people are close to the couple or the individual and often share similar personalities. Their non-judgemental attitude is helpful.

General practitioners and health visitors represent professional sources of support. Community psychiatric nurses and counsellors are often the second level of service provider, after a referral from another professional. Professionals are expected to provide information and refer to other workers. They are expected to open up communication and be able to recognise when a problem develops. Effective helpers are prepared to listen without being judgemental. The characteristics of the professional helper are knowledge, impartiality and professional distance. Emotional turmoil is more easily dealt with and the family can be protected from upset. When services are perceived to be focussed more on physical rather than mental illness, access is less likely.

Contact with both groups of helper is based on a trusting relationship and an ability to understand the respondents' difficulties. Different helpers fulfil different functions for the couple. While lay-people such as family and friends mainly provide informal help, professionals are expected to offer

assessment and therapy. The latter can be limited by resource constraints and access difficulties.

5.4 Conclusion

The above narratives illustrate the different areas, which were explored during the first stage of the analysis. Following initial coding, categories and subcategories were identified based on the emergent concepts and grouped into thematic category networks. These provided a working overview of the issues raised by the respondents and contributed to the formulation of early hypotheses. In addition they are the basis for some in depth analysis of key issues related specifically to the areas of interest to this study. The respondents distinguish between the various helpers and the functions, which they expect them to fulfil. The role of the helper and their relationship with the person receiving the help are considered. The respondents find it useful to have access to a range of different helpers, both lay and professional, to meet their changing needs at different stages of the illness.

During this first stage of the analysis, open coding resulted in a large number of codes, which were subsequently reduced and formed into concept groups to aid early category development. Axial coding was then used to define seven key categories and their subcategories. The category networks described above facilitated this process and allowed me to gain an overview of the data. It helped me to propose a structure from which to develop my early hypotheses for testing during the next stage of the analysis. The respondents' narratives focussed particularly on the impact of postnatal

depression on the couple relationship and support issues. They aided the integration of the emerging concepts and contributed to the formulation of tentative hypotheses.

The next stage of the analysis expands on these aspects of the analysis by utilising axial coding to test the emerging hypotheses against the categories identified, focussing on relationship issues and support issues. Mini frameworks illustrate the relationship between the concepts thus refined and contribute eventually to the final grounded theory processes proposed in this thesis.

Chapter 6 Findings stage 2: Category frameworks

6.1 Introduction

This chapter focuses on the second stage of the analysis, which expands the concepts and categories developed during open coding. Axial coding was utilised to test the hypotheses developed in stage one of the analysis against the category networks, focussing specifically on relationship- and support issues. Mini frameworks were developed, which illustrate the relationship between the concepts thus refined. These inform the third and final stage of the analysis and contribute to the final grounded theory processes proposed in this thesis.

This stage of the analysis reflects the interplay between the deductive and inductive aspects of grounded theory. Through the return to the data, tentative hypotheses proposed initially, are reviewed. I checked the data particularly for outlying cases, which may not match the proposed hypotheses and, in turn, may require that the hypotheses need to be adjusted in the light of the new evidence. The data collection period for this study stretched over a period of six months between first and last interview. This allowed me to utilise the transcribed interview data as well as the final interview with the couples to check the emerging hypotheses. In this way I was able to clarify any questions, which had arisen during the initial interview and confirm my findings with the respondents.

This chapter begins with a conceptual map, which illustrates the link between the various components relevant to the couple's experience of postnatal depression and their support issues. As part of the analysis, the categories proposed in stage 1 of the analysis were reviewed, renamed and abstracted further to become part of the stage 2 categories. This ensured that the new categories were embedded in the original category networks developed during stage 1 of the analysis. The components of the stage 1 and 2 categories were compared and contrasted, codes allocated to more than one subcategory were reallocated and the dimensions of each of the categories described in more detail. Two category frameworks emerged from this process, linking the various categories thus identified to each other and to the area of interest for this study. These frameworks provide an overview of the interaction between the various aspects of the respondents' experience of postnatal depression and of the key issues, which influence their perception of the support available to them.

It could be argued that this concludes the study and meets its aims. However it fails to meet the requirements of grounded theory and its stipulation to develop a theoretical framework to explain the phenomenon of interest (Strauss and Corbin 1998). In particular two unexpected concepts emerged during the first two stages of analysis and demanded expansion. These related to the redefinition of the couple's normality as a result of postnatal depression and their search for help from various support networks. They are discussed in more detail in the next chapter (chapter 7), which explores the core processes proposed by this study.

6.2 Early themes and their development

During the second stage of the analysis, the categories proposed during stage 1 in the previous chapter were reviewed and abstracted further. Axial coding supported this process and helped to develop two frameworks, which describe the relationship between the various components thus identified. Table 25 below demonstrates the link between the seven stage 1 categories described previously and the stage 2 category frameworks (also see appendix 7 for more details). This strategy reduced the numbers of categories identified during stage 1 of the analysis to two new category frameworks. Related subcategories generated during the first stage were allocated to both new frameworks. During this process the original data were checked for outlying cases to ensure that the proposed hypotheses reflected the perspective of all respondents.

Stage 1 category	Stage 2 category framework 1: experience of PND	Stage 2 category framework 2: support issues
Causality	Speculation about causality	Outcomes People
Emotional health	Strive to achieve normality Strength of relationship	Outcomes People Format
Access	Coping strategies Strive to achieve normality	Outcomes Characteristics
Roles and gender	Speculation about causality Strength of relationship	People Format Characteristics
Professionals		People Format Characteristics
Solutions	Coping strategies Strength of relationship	Format Characteristics
Help seeking	Coping strategies Strength of relationship	Outcomes Characteristics

Table 25 Linking stage 1 categories and stage 2 frameworks

The categories identified in stage 1 of the analysis link to the two category frameworks, which describe the experience of postnatal depression and the support issues relevant for the respondents. Their various elements evolved from the category networks identified during the first stage of the analysis. Category framework 1 represents the experience of postnatal depression for the respondents and the factors, which influence their response to the illness. Category framework 2 summarises the support issues highlighted during the interviews and the areas of concern identified by the respondents.

6.3 Framework 1: The experience of postnatal depression

The first area of interest to this study was the couples' experience of postnatal depression. Framework 1 focuses on three distinct categories. These relate to the speculations around the causality of the illness, the coping strategies reported by the respondents and their desire to return to a previous normality. An underlying theme to these three areas is the strength of the couple relationship, which affects their perception of the illness and their experience. Making sense of their experience raises complex issues in the relationship, which the respondents feel more able to address within the context of a relationship which values commitment. The stronger the underlying relationship is perceived to be, the more likely the partners are to remain together and negotiate the challenge of postnatal depression successfully.

Each of the categories outlined are characterised by specific dimensions, which demonstrate their scope. The first category, 'speculation about

causality', has two dimensions. These relate to the respondents' understanding of the illness, its physical or social origins. The physical factors mostly identified relate to the effects of hormonal changes or the impact of a traumatic birth on the mental health of the woman. The social factors highlighted focus mainly on the changes to the partners' roles. These are brought about by the couple's adjustment to the new baby, to parenthood and to the emotional challenges of a, at times, difficult infant.

The respondents identify two dimensions of coping strategies. One is the presentation of the woman's self and her desire to 'keep up appearances'. The other is her response to the illness based on a comparison with others such as peers, images presented in the media or by professionals.

The third category in this framework represents the couples' desire to achieve normality. Here the respondents reflect two dimensions: the maintenance of an image of normality and a comparison between their previous self and their current experience. The maintenance of normality is achieved through a significant personal effort to mask the changes experienced and an expressed need to minimise the effects of postnatal depression wherever possible. The comparison with a previous self includes the need to revise previous parenting expectations or an acceptance that the previous self has been lost.

Throughout this framework, an underlying theme of significant importance to the respondents is the strength of the relationship, which affects how they

experience the illness. This is assessed and characterised by the extent of the communication between the partners and the degree of intimacy experienced. Feelings of insecurity and confusion can arise when the underlying relationship is challenged and perceived to be at risk.

The framework presented below illustrates the complexity of the interaction between the various factors, which affect the couples' experience (figure 12). The four categories in this framework are represented on the central axis of this figure with the subcategories 'speculation about causality', 'coping strategies' and 'strive to achieve normality' intersecting the underlying fourth subcategory 'strength of the relationship'. All categories reflect a dimensional continuum, the end points of which are indicated at either end of the relevant subcategory. For instance the two dimensions ('physical', 'social') for the category 'speculation about causality' are positioned at each end of the horizontal axis for this subcategory. The two dimensions ('communication/intimacy', 'insecurity/ confusion') for the category 'strength of the relationship' can be found at each end of the vertical axis at the centre of the figure.

Some aspects of these categories are of greater importance to the men, while others are more likely to be raised by the women. The men for instance often comment on the causality of the illness and the possibility that hormonal changes or traumatic birth events are responsible for their partner's distress. The women are more likely to focus on the emotional challenges of a difficult baby or the role changes imposed on them as a result of motherhood. While this highlights some distinction between the two partners,

both men and women comment on similar aspects of their experience and its effect on the management of the illness.

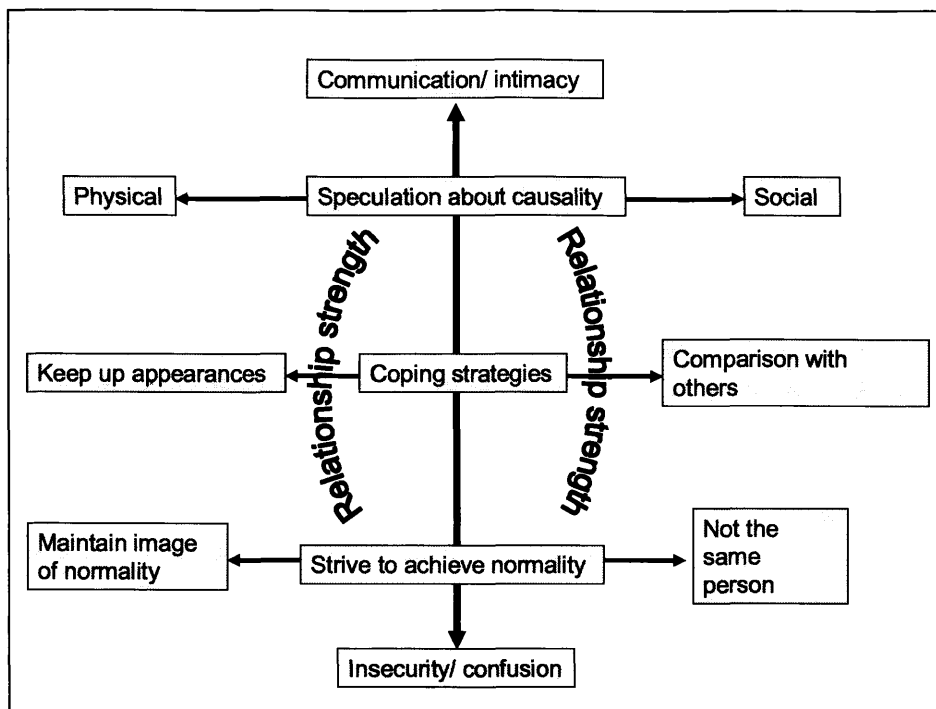


Figure 12 Category framework 1: experience of postnatal depression

6.3.1 Speculation about causality

Stage 1 of the analysis noted that both men and women ascribe significant importance to the identification of the causality of the illness. This category was included here with a specific focus on the physical and social causes ascribed to the illness. Karen described how she speculated on the various causes of her illness. She considered hormones, a possible transient change in her metabolism, personal shortcomings and an inability to adjust to new parenthood. She identified causes in both dimension of this category i.e. the physical challenges of childbirth but also the social adjustment to a new baby and related demands on her as a person.

Karen, interview 2

It's really your body's metabolism or whatever the heck it is, is really calling the shots. It's not your, you saying "I want to be depressed". It's like your body's just decided this is what's happening to and it's something to do with your character and your personality that's made you get postnatal depression. You failed in some way rather than you just, just for some reason, you've had a baby and that's what's happened,

Dana and David first focussed on the physical causes of the illness but emphasised its social causes more as the illness progressed. The latter gained in importance as it became apparent that Dana's symptoms were more than transient.

Dana, interview 1

we both thought it was just tiredness. I can remember you saying to me, stop crying and get some sleep. I just couldn't sleep, because of all these thoughts in my head.

Irene focussed more on the social dimensions of the illness. She described the changes in her role as a new mother and the challenges this transition represented to her emotionally. The need to bond instantly was important to her and based on social expectations. When this did not happen, she had to readjust. She felt that changes in her role contributed to the development of her illness.

Irene, interview 2

I expected, you know, to instantly bond with her instantly. Yeh, turn into that perfect mother over night almost. I expected I'd feel a lot different than I do now. I didn't expect it to be quite so hard I think.

While role changes were significant for Irene, Dana described the changes brought about by the arrival of a new baby. During the interviews Dana and David described their daughter as a difficult child, reluctant to respond to

expressions of parental affection. Although this was an issue for both parents, Dana attributed the baby's response to her directly to her illness. David was often able to calm the child when his wife had failed to settle her despite repeated attempts to do so. In the extract below, she described her complex emotional response based on the social expectations of motherhood and a natural bonding process between mother and child. She felt that her own illness contributed further to the child's challenging behaviour.

Dana, interview 1

She was very good with you, she probably picked up from me, all those vibes, it was like she really didn't like me and it got to the stage in the autumn, ehm, I really didn't like her. I could have quite happily given her away to a nice home or people. I really didn't like her. Really didn't bond

Speculation about the causality of the illness is not confined to the women. The men also explored the reasons for their partners' symptoms. They tended to focus more on the physical causes of the illness and find it easier to understand their experience within this context. Chris' description of his search for answers reflected his confusion. He speculated about a range of physical causes such as tiredness due to lack of sleep and the physical effects of perinatal surgery on his partner, Carla. He also explored the challenges posed by the concerns for the child's health during pregnancy and immediately after the birth.

Chris, interview 3

We thought we were going to lose the baby early on and because of the procedure that she could lose the baby, so that was quite, so it was quite, it was quite a stressful 9 months..... 0766:0768She's no getting enough sleep and I know that enough to eat and she's no feeling well and stuff like that eh cos of the operation.

All couples are concerned to understand the reason for their emotional problems. They are uncertain about this aspect of their experience and attempt to resolve it by speculating about the causes of the illness. It is important for the couples to seek an understanding within the context of their personal experience to guide their response to the illness.

6.3.2 Coping strategies

The experience of postnatal depression is further affected by the approach the couples select to respond to the illness. The category 'coping strategies' incorporates issues of access to help, the solutions and help seeking identified in stage 1 of the analysis. Two dimensions of this category are of particular interest here. One relates to the woman's presentation to others and her need to maintain an appearance of functionality. The other focuses on her interaction with others and the effect of a comparison with others perceived to function effectively influences the management of the illness.

Dana described her efforts to maintain an image of functionality to family and friends. Both partners were engaged in this process. Neither shared her diagnosis with close relatives or acquaintances to avoid negative judgements. Dana's perceived need to act differently appeared to be drawn from a specific interpretation of social expectations. These appeared to have informed the couple's interaction with her family and continued well beyond the end of her illness. Since particularly Dana had a strong sense of failure as a mother, this explanation might have helped her to manage these feelings more effectively.

Dana, interview 1

You feel you have to be a different person... I mean we didn't really tell your family about it, sort of kept the tablets hidden when we went on holiday and stuff.

..... So it was a very hush, hush, and of all our friends, hardly anyone really knows, do they?

Aileen felt that, like an actress, she needed to perform for an audience. She attempted to include herself in this audience, but found that this strategy eventually ceased to be effective. She had to drop the mask and admit her difficulties to herself and those around her.

Aileen, interview 2

you do, you don't want people to know how you are; you become a good actress... you just want to convince yourself: you can be ok, you will be ok. And then there just comes a time when, even when I was talking. I canne hide it,

Overcoming these barriers eventually can open up channels of communication and access to help. Having attended a local mother and baby group for some time, Jane was able to overcome her initial desire for secrecy. She received a positive response in return for her openness and formed new and supportive friendships with the other women. Having been open about her problems, she was later able to draw on the support of these friends when she was unwell. She valued their unconditional acceptance of her difficulties.

Jane, interview 2

I think that's the most important thing I had to do was first of all tell them how I was..... after a few weeks, I told them and they're still my friend now.... They're not thinking "She's a bit weird. I don't want to catch it or anything"

Carla described a similar her relief once she was able to admit to her problems. This opened up the possibility for an improvement and recovery.

Carla, interview 2

to keep up the front all the time, to keep up the face all the time.... It's so exhausting. At least then, when you've admitted to people, you can start to feel a wee bit better about it.

The women find it reassuring to know that their experience is not isolated but common to others in a similar situation. Whether this comparison occurs informally in conversation with other women, in a group setting or is highlighted by a helper is less relevant than the feelings of isolation experienced otherwise. Although Hannah had not been able to benefit from this support, she felt that it would have helped her to make sense of her experience and gain access to help. Hannah suggested that a shared perspective could have helped her manage her illness better. Her comments reflected not only her own sense of isolation but also her need to seek out other perspectives to understand her experience.

Hannah, interview 2

you would have felt less like there was a nut in your head... there was some reason why you were feeling it So I think if somebody had picked up on it, it would have been easier.... you're not just the only one that's ever felt like this and, you know, other people realise that as well."

Sharing a common experience in a support group also had negative implications and increased Dana's sense of failure.

Dana, interview 2

Like I say every other mum seems to be looking nice and nice baby and happy with it all and you just don't feel like that.

Pam observed other women who seemed to enjoy their new motherhood but felt unable to meet these expectations herself. Instead of providing reassurance, her observations reinforced her feelings of personal failure.

Pam, aged 37, administrator, postnatal depression after birth of second child, interview 2

they seem to be getting on fine and coping well and you think...Why can't I be normal sort of thing, you know? you see all those other people going down the street with a smile on their face and their babies and things and you think, well why can't I just be that way as well?

All the women hide their difficulties from family and friends initially but express relief once they are able to share their feelings. It facilitates access to help, which was previously not available. Most women find that sharing their experience with others can be reassuring. For some the comparison with others can be threatening and reinforces a sense of personal failure.

6.3.3 Strive to achieve normality

When the respondents describe their experience of postnatal depression the desire to achieve a specific normality is a recurrent theme. Normality is defined by the couple within the context of their relationship. This aspect was included as a separate category in the above framework. It is integral to the respondents' understanding of their experience, allows them to make sense of their difficulties and maintain their relationship against significant challenges.

Preserving an image of normality and a comparison with a previous normal self are the two dimensions of interest in this category. The first reflects the

couples' desire to manage the change brought about by the illness and to minimise the effects of postnatal depression. In this way stability in the relationship and the family unit are retained. A perception that the woman is not the same person as before informs the second dimension of this category. Both partners compare their current experience with their previous perception of themselves. They judge their experience of postnatal depression based on their parenting expectations and the loss of a previous self. This category links closely to the previous category 'coping strategies'. It picks up the concept of 'normality' as defined by the couples and expands it further in terms of a potential overarching theme central to the couples' experience.

Oscar described his reaction to the changes he observed in his wife. He experienced two episodes of postnatal depression, which changed his attitude to Olive's illness. Initially, he expected parenthood to be a normal process, easily managed. As he gained experience of parenting, he revised and adapted his interpretation of her behaviour accordingly. His early reluctance to accept a possible deviation from the perceived 'normality' of an uneventful transition to parenthood reflected his desire to retain a sense of stability. Oscar's comments appeared to suggest a degree of intolerance towards women who were unable to negotiate motherhood competently. He professed to have become more accepting of differences in experience and circumstances. It was unclear whether his remarks reflected a change in attitude or a desire to present views considered more acceptable to the interviewer.

Oscar, eight years difference between partner's episodes of postnatal depression, interview 3

Yeah in the early stages the last time it was like that... you think 'oh pull yourself together; it's just the shock of having the baby and when you hear likes of them all coming up and saying 'aye I had 3 kids, never bothered me' ...is it just you looking for sympathy or you canna cope, pull yourself together I suppose every woman should be able to bring up her own kids and no have a problem but I would sayit affects everybody differently, having children.

Other couples focus on the link between their expectations of themselves and their response to the illness. Evelyn's strong expectations of herself as a good parent contributed to her feelings of guilt, when she did not achieve this goal. The concept of a 'good mother' for her described the normality to which she aspired. As a first time mother, her aspirations were based on social and cultural expectations internalised from a range of sources.

Evelyn, interview 1

one of the main things with postnatal depression is the guilt. You think you're a bad mother, you are meant to feel happy

All respondents stress their desire to return to a previous normality familiar to them as a couple. Dana and David wanted to return to a previous closeness in their relationship, which formed part of their definition of normality.

Dana, interview 1

Just wanted us to be like a huggy cosy, couple again, which we had once been years before

Close physical contact and its absence defined normality and abnormality for Norman. He later identified other markers such as the ability to socialise, enjoy the company of friends and share activities with his teenage son. Although presented in a matter of fact style, Norman's list of lost activities

reflected a sense of sadness and distance from his wife and son. He appeared to hide his feelings behind a mask of businesslike pragmatism with a choice of short and unemotional sentences.

Norman aged 30, production manager, interview 3

we are quite touchy feely physically then I think that was put to the side if you like 959-966 having a son just getting at that age when he really wants to start getting I would have liked him involved but the option wasn't there.

Rachel used her definition to measure her recovery from postnatal depression. While this process was long and strenuous, she knew when she had reached her goal: the top of the cliff. She measured her personal normality by her ability to laugh at herself, to be spontaneous and confident in her own abilities. Rachel's considered perspective may have reflected her long process of recovery (seven years since her initial diagnosis) and life experience.

Rachel aged 39, seven years since diagnosis, interview 2

It's like scrambling up a cliff... I guessWhen I can laugh at myself..... My ability to, you know, got enough confidence to just do what I want. There's a load of little things really. They all add up to me moving on

All respondents express such a desire to return to a previous normality. The women describe the attributes, which they value in themselves. The men comment on the personality and behaviours, which they appreciate in their wives. Striving to achieve these is the goal for recovery.

The category 'achieve normality' contains two specific dimensions of interest for the experience of postnatal depression. These relate to the perceived

need to maintain a functioning image to others and the comparisons the women and their partners make against their former selves. Both aspects of this category affect the couples' response to the changes experienced by them. Sometimes, the wish to maintain normality can block access to help and affect the support available from the other partner. At other times it can result in feelings of regret and frustration. For most respondents their definition of normality represents a goal and an indicator for recovery.

6.3.4 Strength of the relationship

All three categories are informed and supported by the final category: 'strength of the relationship'. This is central to the experience of postnatal depression and the difficulties posed by the illness. The two dimensions of this category are the need for intimacy and communication versus confusion and isolation. When the partners feel able to communicate and maintain a sense of intimacy, they are more able to work through any challenges. The process is facilitated by an underlying perception that the relationship is valuable and worth saving. This does not exclude the possibility that feelings of confusion and isolation from the partner can arise, which put pressure on the relationship. Bert explored the first dimension in some detail. He commented on the potential challenge to the relationship posed by the illness but also maintained a sense of pragmatism. Neither Bert nor Barbara felt that the strength of their relationship was threatened but acknowledge feelings of disharmony. Their commitment to each other and their sense of joint responsibility allowed the couple to retain their intimacy with each other and to overcome their difficulties.

Bert, interview 1

the relationship was strained, but I wouldn't have said it would have pushed us to the limit. I have had enough of you; I want to get out of this.

..... I couldn't see myself saying: 'right deal with it yourself.' That wouldn't have been fair, to leave her like that. And I felt well, two is bigger than one. So I felt, I had to help her whatever I could to get her to the other end of the tunnel.

In contrast, Jason had had unhappy relationships with previous girlfriends and felt insecure with Jane. Her illness and the associated loss of intimacy left him with feelings of doubt about the strength of their relationship. This couple worked through their feelings of rejection and loss based on Jason's commitment and hope that the couple would return to their previous normality.

Jason, interview 4

I know that's she's depressed and that I'm depressed and that at some point.....we'll be how we were before any of the depression started so I'm just hanging in there and finding things a little bit easier as I go along now.

Barbara experienced a similar loss of intimacy. She was unable to express her feelings for her partner and felt guilty that she had rejected him, although she had remained committed to the relationship throughout her illness.

Barbara, interview 2

I mean it hadn't changed the way that I felt about it but maybe I couldn't show it as much as what I could, you know, before then and what I could now. It was, you know, as if maybe part of me wasn't there any more

Table 26 below illustrates the patterning of responses for the components of this framework. Most couples attributed the illness to both physical as well as social factors. Two felt strongly that physical causes were to blame for her illness while four specifically mentioned social causes such as changes in

role and social isolation. Olive and Pam and their partners interpreted their experience from the perspective of two episode of postnatal depression and might have felt that they had adjusted to their role of motherhood after the first pregnancy. An attribution of their depression to the physical event of childbirth would have been more reasonable in their situation. Aileen, Barbara, Irene and Lena focussed specifically on a social explanation of their illness. These women felt under pressure to respond to a difficult social situation. Barbara felt ostracised by members of her small rural community while Irene felt socially isolated from her family and peers. Aileen and Lena also felt isolated due to the geographical distance away from their families but were able to draw on other social support as they developed their own local support networks. For these couples their social environment felt unsupportive and even hostile which may explain their attribution.

All couples mentioned one or other aspect of their coping strategies. Some focussed more on their efforts to maintain a functioning image while others compare their own experience with that of other families around them. For three couples both aspects were important. The need to keep up appearances was important for the women who felt an obligation to protect their partner or their wider family network. These women appeared to be older than their peers but did not differ from them in their social background. Their decision appeared to be informed by a personal sense of responsibility towards others. Other couples focussed more on their efforts to assess their experience informed by a comparison against other young families. These couples were of mixed social background and age.

The desire to achieve or return to a previous normality was shared by all couples as was their expression of a commitment to their relationship based on mutual affection and regard. Only one couple, Frances and Freddy, differed in their statement from the other respondents. Both stated that they had remained in the relationship due to a sense of responsibility towards their children. This couple was perhaps more honest about their motivation or were unusual for this cohort. It is possible that the other respondents felt a genuine sense of achievement at having managed to respond successfully as a couple to the challenge of postnatal depression. This sense of achievement was not apparent in Frances and Freddy. Whether this attitude might have been a reflection of their age is questionable, since Rachel and Richard, the other older couple, shared a more positive perspective with the other respondents.

The couples attach importance to the strength of their relationship and note its influence on their response to the illness. Both partners comment that they are more able to address the complex demands made on them if they value their relationship and feel a strong sense of commitment to it.

Couple name	Ages of partners	Speculation about causality	Coping strategies	Achieving normality	Strength of relationship
Aileen/Alan	35/30	Social	Appearance	*	*
Barbara/Bert	32/30	Social	Comparison	*	*
Carla/Chris	27/29	Physical/social	Comparison	*	*
Dana/David	36/35	Physical/social	Appearance/ comparison	*	*
Evelyn/Edward	35/36	Physical/social	Appearance	*	*
Frances/Freddy	42/41	Physical/social	Comparison	*	Commitment to children
Gina/George	28/32	Physical/social	Appearance	*	*
Hannah/Harold	31/26	Physical/social	Comparison	*	*
Irene/Ian	28/26	Social	Comparison	*	*
Jane/Jason	24/18	Physical/social	Appearance/ comparison	*	*
Karen/Kurt	31/30	Physical/social	Comparison	*	*
Lena/Len	34/41	Social	Appearance/ comparison	*	*
Maureen/Mike	30/24	Physical/social	Comparison	*	*
Nancy/Norman	30/29	Physical/social	Appearance	*	*
Olive/Oscar	34/35	Physical	Appearance	*	*
Pam/Paul	38/37	Physical	Comparison	*	*
Rachel/Richard	40/39	Physical/social	Comparison	*	*

Table 26 Patterning of responses to the framework: experience of postnatal depression

* indicates that this issue was raised by the partners during at least one of the interviews

6.4 Framework 2: Support issues

The second area of interest focuses on the support issues, which are important to the respondents. This framework consists of four categories, which are closely interrelated. The format of the help and support received from various helpers is the central theme. It interlinks with the other three categories, which describe the people providing the support, the characteristics of the help available and the outcome of the support received. The format of help contains both practical and the emotional elements, which inform the respondents' assessment of any support activity they receive. Help is received either from individuals or groups of various descriptions. It can be either effective or unhelpful, characteristics by which the respondents judge the help available to them. The partners judge the outcome of any helping activity against the goals they set for it and the impact the help has made on the woman's health and the relationship. The category framework below illustrates the relationship between the various concepts derived from this second stage of the analysis (figure 13). The central category 'format of support' is represented by the central axis in figure 13 below. Its link with the other three categories in this framework ('people', characteristics', 'outcomes') is illustrated by their intersection with this central axis. All categories have dimensional endpoints which are positioned at either end of each category axis. For instance the category 'people' has two dimensions ('individuals', 'groups') which can be found at either end of its horizontal axis. These categories are summarised below and the specific components of this mini framework listed in more detail in appendix 8.

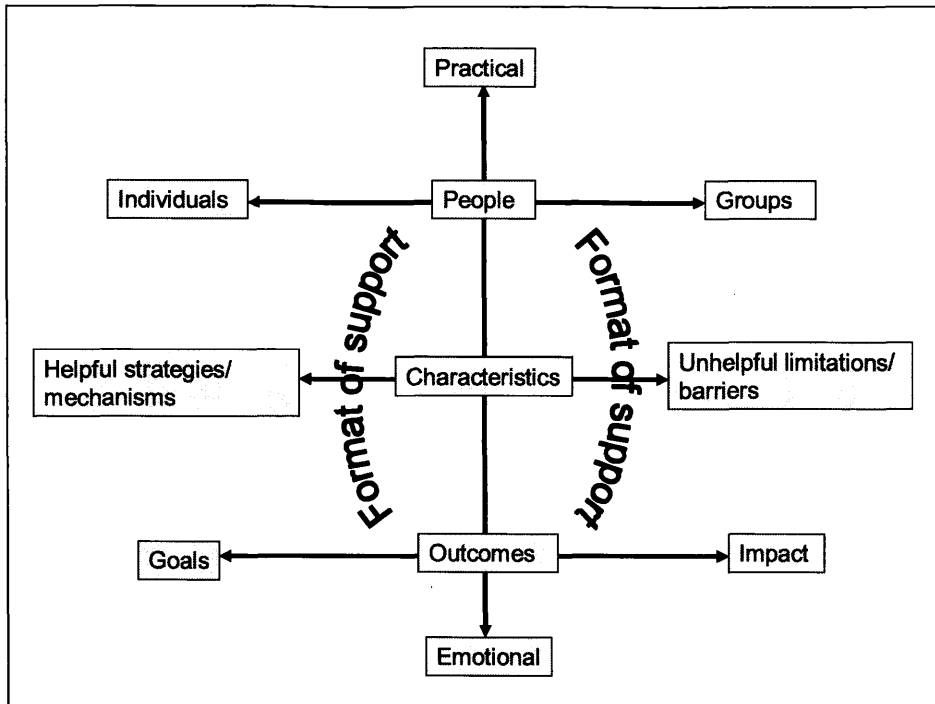


Figure 13 Category framework 2: support issues

6.4.1 Format of support

Helpers support the woman through either emotional or practical activities. Practical tasks consist of help with household duties and childcare, access to support networks, information and medication. Emotional support provides opportunities to talk and be listened to with understanding and encouragement. While both of these components are important, different helpers are perceived to have different strengths. For instance some helpers are valued for their practical support. Others provide mainly emotional support. Kurt for example helped Karen with practical tasks such as household chores and the care of the family pet. He contrasted his own activities with those of other men he knew, who would not support their

partners in this manner. He also acknowledged that he enjoyed these chores, which were easy for him and provided him with a sense of satisfaction.

Kurt, interview 1

Other guys are quite happy sitting and not make the tea It doesn't have to be a lot. You take the dog a walk, make the bottles up, make the tea. Something you can do. Something you enjoy doing even

Maureen focused more on the emotional help she received from her own mother such as relationship advice and life experience. She valued her mother's life experience and their close bond, which helped her maintain her relationship with her partner.

Maureen aged 24, urban environment, lived close to own family, interview 2

we've had this big obstacle put in our way so, you know somebody who's got more years than you and I value her opinion as well then it's sort of made it a lot easier and it has, you know, kept my relationship, quite an important thing rather than letting it slip

Throughout the interviews, the respondents returned to the various examples of practical and emotional support, which they received and valued. Some couples expressed their regret that they had been unable to access either type of support. At times this was due to an inability to express their need for help. Others made a conscious decision to limit their requests for support to a very small group of helpers whom they could trust.

Irene and Ian contrasted the different members of their families to illustrate different aspects of help and its limits. Both partners were able to benefit from emotional support and quiet listening, which Ian's father provided. He listened without giving advice. In contrast, similar help was not available from

their respective mothers. This couple had expressed their dissatisfaction repeatedly but felt that their request for more empathetic support had been ignored.

Irene and Ian, two years since diagnosis, interview 4

Irene: He's there to talk to but he doesn't constantly try to interfere and tell you how to do things.

Ian: He just listens where my Mum, I don't think my Mum listens at all... she just ignores it if you say something, she knows five different ways; you should be doing it better including raising the children and stuff like.

Although this couple had tried unsuccessfully to engage their families in specific support activities, they continued to explore opportunities to obtain both practical and emotional help from them. Irene described the practical help she expected to receive on her visit to her family, which she hoped would allow her a welcome break from her daily chores.

Irene, interview 4

I don't get on that well with his Mum but I love his Dad and I am really looking forwarding to it. Someone else to do the cooking, you know not having to worry about cleaning. They walk the kids for us now and again

Some couples, like Irene and Ian, remained optimistic that they would receive help from their respective families. Other couples adjusted their expectations of help based on their previous experience. These couples decided to contain their difficulties within a small network of close helpers. Nancy and Norman for instance had tried to seek help from Norman's parents but had met with incomprehension. The couple excluded his parents altogether and sought emotional and practical support mainly from Nancy's mother.

Norman aged 30, production manager, two years since diagnosis, interview 1
My parents have no, had no comprehension or understanding of postnatal depression and I had no support, they used to what's the problem type of thing ...and so I had no support network from my family, the support network we had was from your mum really

Norman initially tried to support his wife as much as possible while working full time and contending with a precarious work situation. He provided practical support to Nancy on his return from work, doing the household chores and care for the baby. This couple eventually took up the offer of help from her parents. Nancy moved a considerable distance away to stay with her parents. Norman was only able to visit at weekends, driving four hours at a time to see his wife and child. Although this was itself stressful for the relationship, they felt that the practical and emotional support received from her parents helped them through the worst time of the illness.

The format of the help potentially available is important to the respondents. This can be either practical or emotional but is also influenced by the couples' previous experience of the likely response from the helpers. Some couples comment on the positive benefits gained from practical and emotional support. Others have expectations of the support they would appreciate but have not been able to access.

6.4.2 People providing support

The format of the help available or desired is closely linked with the other categories in this framework. Support can be available from a number of individuals or groups. These include the immediate partner, close family members, friends or individual professionals. Group support is available from

formally and informally convened groups. Mother and toddler-, breastfeeding- or postnatal depression groups are included in this category as well as social groups of mothers meeting informally. These groups are seen to be specific for the women and unlikely to be accessed by the men. Some of the men would consider support from other parents in a group under specific circumstances. A number of conditions apply before help from these potential helpers becomes available.

Karen for instance commented on the help she received from her partner, Kurt. She appreciated this but also needed to be able to share her experience with other women. Kurt's presence and sympathy were welcome but were only one aspect of the help she required. For her the opportunity to discuss her feelings with friends was similarly important. Karen's previous comments had suggested that she might have resented Kurt's frequent absences at work but had also accepted the need for him to support the family financially. In the following sentences she appeared to downplay Kurt's importance as a helper further. She emphasised the importance of sharing experience with other women and allocated minor importance to her husband's efforts to help. Her comments might have reflected both an underlying sense of disappointment and a possible need for a range of various forms of support.

Karen, interview 2

even if he had been home... it wasn't just him being there. It was female company and other mums' company that I needed to share the experience. Not just husband being supportive and making cups of tea.

The other women also talked about their need to share their experience with others beyond the immediate couple relationship and access a combination of different helpers. At times, the need to speak to others outwith the immediate couple relationship arose from a desire to protect the other partner. Barbara for instance was more able to talk to her community nurses about her suicidal feelings than to her husband. Bert speculated that she had tried to protect him from worry and more concern. Whether this was the only reason was unclear. It might have been a more acceptable explanation for Bert to accept than the possibility that the relationship between the partners was not close enough to discuss such a sensitive issue.

Bert, interview 3

maybe she was trying to protect me. they weren't connected to us, like family, so she found it easier to tell them She wouldn't wantme to worry.

Not only the women but also some of the men seek support from other helpers. Carla and Chris both discussed postnatal depression with Chris' sister but sought different information. Carla wanted to discuss her feelings and experience, while Chris needed guidance on strategies to support Carla. He acknowledged his sister's role as a confidante outwith the couple relationship.

Chris, interview 3

My sister's had it and she, she would point me in the right direction about things she would probably give me advice more than anything else. She wouldnae give me anything medical she just said "look if she is going to be like this, the best thing to dae is, what I used to dae this or dae that, give her a cuddle or something like that".

The respondents not only comment on the support available from individuals but also from others such as members of various support groups. This can be a useful opportunity to exchange experiences and gain emotional support. The severity of their illness can make this a challenging setting. Attendance at the local mother and baby group run by a health professional became more difficult for Hannah as her mental health deteriorated. Although she had initially enjoyed the exchange with other mothers, she became increasingly uncomfortable in the group based on her own sense of inadequacy as a mother. Only as she began to recover from her illness was she able to return to the group. Her support needs changed as her mental health changed. Support from a group of other mothers was beneficial while she felt relatively well. Later the comparison with others, perceived to be more successful as new parents, became unhelpful and threatening.

Hannah, interview 2

I went to a mother and baby class but then I really, really tailed off going there when I started to feel so low I wasn't able to interact with the other mothersbut then once I got on the medication, started to feel better, then I started going back to them again.I didn't want to be involved, you know, with other people, hearing how fantastic they were getting on with their babies and how wonderful life was

In contrast, none of the men had experienced support from a group of others but expressed their regret at not having been able to utilise more emotional support for themselves. George felt that this was a specific issue for men who were more likely to use the contact with other men as a social activity rather than an opportunity to explore their emotions. George and his friend would only occasionally touch on more personal issues during their conversations.

George, interview 3

The biggest problem here is the man! ... they'll talk about football and women and exciting films. ... It's like a big girl kind of thing. Even if everyone of us is probably feeling the same way. It's a sort of a taboo subject how you feel. ..very few times, ever, like my best friend and I, we'll have a talk about how we are feeling

George felt that his personal support needs were less important than Gina's.

The aim of the help he tried to provide was focussed on her recovery and any activities to improve her well being. His own needs were secondary.

George's comments were open to two conflicting interpretations: a selfless desire to support his partner or a withdrawal from the complexity of the situation. George's action appeared to support the former view since he encouraged Gina to seek support from a range of agencies. How much he also needed to ensure that the problem was 'fixed' quickly, was less clear but was likely to have contributed to his opinion.

George, interview 3

although I was affected, I think it was her that was needing to sort of go and get the help and speak to somebody and sort of get it out her system. if the problem's fixed or made better, then I would have felt better with it

The men are divided between those who would not consider attending a group of peers for support and those who might have utilised the contact with others with a similar experience. Freddy firmly rejected this option: it did not fit his usual strategy of dealing with personal issues. He preferred to be self sufficient when challenged by emotional difficulties. A self-help group was not an acceptable option for him.

Freddy, interview 1

It's no a thing I would have done. No, I'd sort it out for myself. That's the way I've always done it.

Bert, in contrast, was more open to the benefits of support from a group of other parents. Although this option was not available to him, he speculated that such support might have helped his emotional health and provided him with ideas to assist his partner, Barbara.

Bert, interview 1

if you speak to someone that is, a man that has dealt with it a different way altogether, tried to help his wife and says: 'I've done this', if you had that opportunity, you could speak to somebody like this. You could take that on board and try it, if it works

The respondents identify a range of potential helpers. These are individuals, family members or close friends, professionals and peers. The women feel more comfortable to access support in groups, while the men are divided. Some reject this option while others would have considered help from others if it had been available. The people providing support as well as the format, which this help takes are important components of this framework. An understanding of the characteristics of the potential helper and the helping activity is of additional interest to understand the support needs of the respondents.

6.4.3 Characteristics of support

The characteristics of support identified by the couples divide into two: helpful and unhelpful. Helpful and unhelpful characteristics are compared. The latter can act as barriers to effective support. The qualities of the help as well as those of the helpers need to be considered in each category. In addition the respondents' own characteristics impact on the help available. For instance activities, which are perceived to be potentially helpful, are ideally self

generated, responsive to individual need and relevant for the whole family. The potential helper should be consistent and easily accessible, understanding, honest and possibly share a common experience of postnatal depression. In addition the helper should be available without a perceived constraint on time, demonstrating their commitment to their willingness to provide support. While the characteristics of the effective helper are important, the recipient of that help also needs to be ready to accept, be prepared to disclose personal feelings and have a desire to recover.

Jane and Jason had experience of two different professional support systems. For Jane it was important that the help she received included both her and her baby. Her previous contact with professional helpers appeared to her to have focussed solely on the child with little attention paid to her as the new mother. The local services were perceived to have been more helpful since they included her in their care. Throughout the interviews, Jason had expressed his feelings of isolation and his desire to for inclusion. His comments below appeared to have been prompted by these feelings, reflecting not only useful aspects of the professional service received but also his own insecurities.

Jane, interview 2

She seems to care equally about you and your baby. Not just the baby. Whereas before, in England, it was everything were on to the baby and ... I was out of the picture.

Alan felt that support would have been more helpful if it had taken account of his specific needs. His partner, Aileen, had received written information about

postnatal depression, which she had not passed on to him. Alan did not feel that written information was useful. He would have preferred a personal conversation, tailored to his needs. Personalised information is important for the men. The helper should not presume that the approach helpful for one partner is suitable for the other partner.

Alan, interview 1

That's why I think leaflets wouldn't be the best of things cos she might look at it and say "Oh, I'll read that later" and then maybe never get round to reading it and then I would never see it either. So I think actually somebody sitting down and talking would be better than leaflets.

The characteristics of the help offered are significant indicators of its usefulness. They are tailored to meet the individual needs of each partner. This extends to the characteristics of the helper highlighted by Lena in her description below. Both her general practitioner as well as her health visitor demonstrated empathy and an ability to understand her difficulties. Her health visitor responded sensitively to her request for help. She visited Lena at home where she felt safe, accepted her decision to delay medical treatment and provided regular follow up contacts until she felt able to reduce these contacts. Lena also felt able to relate to her general practitioner as both a professional and as another woman in a potentially similar situation. Ultimately her general practitioner had made the decision to prescribe medication, but Lena felt that she had been part of this process. Lena's description reflects the helper characteristics, which are particularly valued. The helper's response to a request for help is significant and affects the recipient's evaluation of that contact.

Lena, aged 41, previously had managed her own business, interview 2

Nothing negative at all. They were both sort of totally supportive and my GP's a lady so, she's just had a baby as well and she's pregnant with another one so she's like empathetic. she [the health visitor] came down the next day and sat and talked to me for about an hour... So she kind of came to see me every couple of days just to sort of talk about it and see how I was feeling in the end ... I went to see the GP... and she said.... "Do you want me to make the decision for you?" So I kind of put it back in her hands and she took the decision to put me on the medication.

Not only are the characteristics of the helper important, but also the ability of the recipient of that help to accept it. Evelyn found it difficult to respond to an offer of medication from her general practitioner. Acceptance of a prescription had personal significance for her self-esteem and generated feelings of failure. Only when she began to distance herself from the perceived stigma of failure was she able to accept the treatment offered. Her description illustrated the complexity of this decision making process.

Evelyn, interview 2

if I had to take anti depressants....then I was somehow a failure. It took me a long, long time to get over that. To realise, you know, this was a necessityBut at the time, I thought, if I have to take medication for this, it's just another failure

Although Karen recognised that she needed help, she wanted to try other strategies herself before accepting medical treatment. It was important for Karen to be able to manage the illness independently. She preferred to explore other options in an attempt to be self-sufficient and to avoid the stigma of mental illness implied by the acceptance of a prescription.

Karen, interview 2

I really wanted to try to get through it without medicine. but I couldn't do it on my own and that's when the tablets really used to kind of help me to get through it.

The respondents comment positively on the help they received but find contact with professionals often less than satisfactory. Dana felt that her local health visitors were busy individuals and did not approach them for help. Only when she spoke to them about her concerns and received a sympathetic response, did this perception change. Dana appeared to be very tolerant of the shortcomings of professional services. This might have been due to her previous work as a nurse or the perceived sensitivities of the interviewer with a health professional background. Her comments also might have reflected a perception that her own needs were secondary to those of the professionals.

Dana, interview 2

I know they are really busy and I think you're always aware that you're taking up their time

Although Frances did have a trusting relationship with her health visitor, this did not necessarily extend to the service available during her absence. When Frances requested additional support, this information was not conveyed to the relevant staff. She felt frustrated and withdrew from this particular service.

Frances, interview 2

my health visitor is very good... when she wasn't there and I spoke to someone else; that was a disaster I was so upset at having to ask, having to be in the position of asking I just never, ever asked again.

The effectiveness of the help given is influenced by the characteristics of the helper, the activity and the recipient. Unrealistic demands by the helper, a dismissive attitude and unhelpful advice can significantly affect the outcome of the helping process. If the helping activity is perceived to be time limited,

with little perception of control by the recipient over the activity, then the outcome can be affected. The attitude of the recipient and the level of severity of the illness are also important. Difficulties in expressing a need for help or a lack of receptiveness can act as barriers to the help on offer. The type of the relationship with the potential helper can affect the recipient's preparedness to disclose any difficulties. The format of the help, the people and the characteristics of the help available all influence the respondents' assessment of the help available. In addition the expected outcome of the helping activity provides a measure of the effectiveness of the support encountered.

6.4.4 Outcome

The respondents base their judgement of the effectiveness of the support available to them on two main aspects: the goals, which the support can help them achieve and its impact on them. The overarching goal of support is the need to increase self-confidence and self esteem in an attempt to facilitate an early recovery. The respondents identify a number of goals, which help them to achieve their aim. For example they seek to distance themselves from the problem, try to gain early access to help and to retain a realistic perspective. Their goals include the desire to enjoy the positive aspects of parenting, achieve a structure to the day, adjust to the illness and reduce the possibility that the condition deteriorates. These can be facilitated by the provision of effective support from the helpers identified above. Alan for instance highlighted his desire to retain a realistic perspective while managing the challenges of Aileen's illness. He was pragmatic in his reaction. While he

acknowledged the difficulties for the relationship he aimed to respond with tolerance and understanding.

Alan, interview 3

I just really cope with it on a daily basis. I don't sit down and think "I've got to get away from her. This is getting me down" you need to understand each other a bit more tolerance.

Jane particularly wanted to regain the level of closeness in the relationship, which had been lost as a result of the illness. The couple were more able to share their difficulties and provide mutual support as they progressed. Jason's ability to understand her problems and offer emotional support helped Jane achieve her goal. Jane's response hinted at previous difficulties. She suggested that this was an ongoing process, which still had to be resolved. Given that this couple had found it difficult to maintain their relationship, Jane's positive perspective might have reflected as much her desire for a successful outcome as the couple's reality at the time.

Jane, interview 2

He has been a lot more supportive of me. we both understand it, we're getting closer together and supporting each other he's been a good strength if it wasn't for him, I wouldn't be where I am now

The couples assess the outcome of the support based on their existing expectations. If the goals, which they have set, have been achieved, then the help is judged to have been effective. If the goals have not been achieved, then this can have a negative impact on the respondents and the outcome of the illness. When support is not forthcoming, it leads to disappointed expectations, isolation and rejection of the partner and other potential

helpers. Respondents comment that help, which did not meet their expectations, can generate feelings of low self-esteem and influence future expectations of support. Hannah and Harold did not feel that his parents had been able to understand their problems. When I returned to interview the couple after six months, Hannah was pregnant and expecting her second child. The partners had discussed in detail how they would manage a recurrence of postnatal depression. Based on their previous experience, the couple decided to exclude Harold's parents from their support network. Hannah's comment demonstrated the pragmatist position adopted by this couple. They recognised the limitations of the help available and adjusted their expectations accordingly.

Hannah, interview 2

they really did not deal with it very well the last time. Mental illness is a sort of taboo issues with them. I think I've come to realise now that that's the way they are, and different and we just have to agree to differ now... (line 329-330)maybe to tell them but not to expect anything from them.

Table 27 illustrates the patterning of responses for the components of this framework. Most couples talked about both practical and emotional aspects of support. Five couples particularly highlighted the emotional needs of the partners and the importance of such support for the relationship. These couples may have felt that this aspect of support was significant since they had felt a sense of personal or geographical isolation from the other partner or their wider family network during the course of the illness.

Couple name	Ages of partners	Location	Format	People	Characteristics	Outcome
Aileen and Alan	35/30	Rural	Emotional	Individual/group	Contrast helpful/unhelpful	Goals
Barbara and Bert	32/30	Rural	Emotional/practical	Individual	Helpful	Impact
Carla and Chris	27/29	Rural	Emotional/practical	Individual	Contrast helpful/unhelpful	Impact
Dana and David	36/35	Rural	Emotional/practical	Individual	Contrast helpful/unhelpful	Goals
Evelyn and Edward	35/36	Urban	Emotional/practical	Individual	Helpful	Goals/ impact
Frances and Freddy	42/41	Urban	Emotional/practical	Individual/group	Contrast helpful/unhelpful	Impact
Gina and George	28/32	Rural	Emotional	Individual	Contrast helpful/unhelpful	Impact
Hannah and Harold	31/26	Rural	Emotional/practical	Individual/group	Contrast helpful/unhelpful	Goals/ impact
Irene and Ian	28/26	Rural	Practical/emotional	Individual/group	Unhelpful	Goals/ impact
Jane and Jason	24/18	Urban	Emotional	Individual	Contrast helpful/unhelpful- different locations	Goals/ impact
Karen and Kurt	31/30	Rural	Practical/emotional	Individual/group	Helpful	Impact

Couple name	Ages of partners	Location	Format	People	Characteristics	Outcome
Lena and Len	34/41	Urban	Emotional	Individual/group	Helpful	Goals
Maureen and Mike	30/24	Urban	Emotional	Individual	Contrast helpful/unhelpful	Goals/ impact
Nancy and Norman	30/29	Urban	Practical/emotional	Individual/group	Contrast helpful/unhelpful	Impact
Olive and Oscar	34/35	Urban	Practical/emotional	Individual	Contrast helpful/unhelpful	Impact
Pam and Paul	38/37	Urban	Practical/emotional	Individual	Helpful	Goals/ impact
Rachel and Richard	40/39	Urban	Practical/emotional	Individual/group	Contrast helpful/unhelpful Different locations	Impact

Table 27 Patterning of responses to the framework: support issues

All couples commented on the individuals who were important to them to provide support. These were mainly family members and friends but also professional helpers. Eight couples had also had contact with various support groups and were able to comment on the help they had received from them. Four couples lived in rural locations, while four couples stayed in towns. Their experience and involvement with support groups appeared to reflect personal preferences rather than the availability of such groups in these particular environments. Karen, for instance, was helped by her health visitor to overcome considerable transport problems to attend a group in her area. Frances' previous experience of group support disposed her favourably to this type of help.

The characteristics of the helpers played a significant part in the respondents' assessment of the support they had received and how this had affected the outcome of the intervention from these helpers. Most contrasted helpful and unhelpful characteristics (see appendix 8 for more details). One couple (Irene and Ian) had felt a lack of support from their families and local professionals, which was reflected in their negative perception of their experience. This may have been due to the fact that Irene had suffered from depression for a considerable time, which had left both partners feeling helpless and frustrated. Two couples utilised their experience in different locations to contrast helpful and unhelpful characteristics of support. Jane and Jason had moved between two locations in the United Kingdom and had contact with different healthcare providers. Rachel had been unwell in Sweden and subsequently received further treatment in Scotland. Both partners compared

these two systems during their interviews, portraying the Swedish approach as more preferable due to its inclusion of the whole family. These couples felt that support, which was inclusive of both partners, had been more beneficial.

All couples assessed the outcome of the help they had received against the goals they had set and the impact it had on their health and well being. Some focussed specifically on the goals, which they felt they wanted to achieve while others commented particularly on the impact the support had had on them. These different foci appeared to reflect the individual's personal response to the experience and existing coping mechanisms.

The outcome of the support provided relates to the goals, which the respondents set. These are expressed in their expectations of the helper or the helping activity. Support can have a positive or negative impact on the outcome of the illness. Unfulfilled expectations lead to feelings of rejection and low self-esteem for some respondents. Others are able to move beyond these and reappraise the potential help available to them for a future pregnancy. The outcome of the support and its related dimensions is the final component of this category framework. It links to the format of the help provided, people providing the support and the characteristics of the helpers.

6.4.5 Conditions for access to support

A recurrent theme informing these categories are the conditions under which the support is accessed. Help giving is often seen as a reciprocal process: where previously one partner has supported the other partner, there is an

expectation that this support should be available in return. Help giving is dependent on the level of readiness to receive help and an awareness of the severity of the illness. Whether the couple perceive the illness to be a joint problem or that of the woman alone is a further consideration. The potential helper requires a certain amount of information to be able to help. This can relate either generally to the condition or more specifically to the individual person.

Bert summarised the various considerations, which he felt facilitated effective support. This information helped respond to Barbara's illness and gauge how best to support her. He needed to know how ill she was, what level of support he should offer but also when to provide space for her to manage the illness herself. Bert appeared to be knowledgeable and in control when he talked about these successful management strategies. However his comments suggested that this knowledge had been gained through a process of trial and error. He appeared to have found it difficult to assess Barbara's level of illness accurately and provide her with appropriate support.

Bert, interview 1

I suppose it sort of gauging how bad something is.you have got to take different levels of depression, somebody might be just slightly depressed, other people might be manic depressant. obviously you have to give a lot of support all the time, but knowing how to tread, when to back off

The level of readiness of the respondents to accept help is a further condition. Lena gradually became aware of the impact of her illness on the well being of her children. She was ready to accept help from her general practitioner motivated by a desire to protect her children. She noted the

sense of relief felt by her, once she had taken this step. Lena appeared to find it difficult to justify her search for treatment based only on her needs. Citing her children's welfare as her main concerns appeared to strengthen her actions. This perspective might have reflected a lack of self worth but also a role perception, which placed her own needs secondary to her children.

Lena, interview 2

when I went to the Doctor's and she put me on them I came away feeling relieved and I felt that I'd actually done it for the kids as much for myself really because I thought that I was wasting their lives

The readiness to accept help can be further affected by a perception that postnatal depression can only be alleviated by the woman herself. In addition others need to be protected from emotional turmoil. Barbara and Bert for instance described their desire to protect Barbara's pregnant sister from additional anxiety.

Barbara, interview 1

my sister, she was pregnant at the time..... I felt, that I didn't want to say, in case it worried her.

If the potential helper is perceived to be too busy or preoccupied with personal issues to provide help, then this person is not approached. Lena for instance did not feel able to approach her friend for help. She was seen to be too busy and had little time to provide support for Lena. Lena appeared to excuse her friend from her obligation on these grounds. Such reasoning might have helped her accept the lack of support from this friend more easily.

It would have avoided the need to acknowledge that this friend had failed to support Lena at a crucial time in her life.

Lena, interview 2

there's my friend... I could talk to about being a parent and, but she's really busy as well. So she's not sort of have the time to help out.

Maureen and Mike considered similar issues when they talked about the professionals involved in their care. They contrasted two individuals: those able to make time to listen and those too busy to get to know them. Mike occasionally joined his wife on visits to the local child health clinic but felt excluded and uncomfortable with the busy atmosphere there.

Maureen, interview 4

she always had five minutes and she, know, tell from the way I was whether everything was all right or whether she needed to come in where I don't see [the other professional] from one month to the next.. It's a really busy clinic and you never get the same person twice,

The conditions which facilitate and impede access to help are summarised below (table 28).

Facilitate help	Perceived reciprocity of obligation in the relationship with the helper
	Level of readiness to accept help
	Level of awareness of the severity of the illness
	"Us" vs. "me" perspective
	Provision of information- this may be general or specific
Impede help	Perception that the experience is internal to the person and can not be alleviated by others
	Perceived need to protect the helper
	Perception that the helper is too busy with own issues/problems
	Expectations of what the helper will be able to provide

Table 28 Conditions which facilitate and impede access

Helping is a mutual obligation for the respondents. Appropriate support needs to be available but the recipient of that support also needs to be ready to accept it. The helper should be able to understand the illness and its severity. Recovery is a joint responsibility for the woman and her helper. A number of barriers, including a perception of personal failure, can obstruct access to help. Both partners express a desire to protect their partner and others from anxiety. If helpers seem to be too busy or unlikely to provide help as expected, they are excluded from the support network.

6.4.6 Support networks

By mapping their support networks with each couple, I was able to identify a number of issues, which were of particular interest. For instance while most women had been able to draw on a number of helpers, the men's network was less diverse. On a number of occasions, close relatives, such as parents or siblings, were placed on the periphery of a network and unavailable to help. Helpers were judged on their perceived ability to be effective as potential helpers rather than on their relationship with the couple. For instance a few couples did not include their parents in the helper network due to a perceived negative attitude to postnatal depression and a lack of understanding.

The couples also used the networks to describe the men's contribution as helpers in more detail. Most of the men saw themselves as their partner's main source of support. Even if they had found the experience stressful and challenging to their own emotional health, they drew a strong line between

themselves and their partner. For some couples, this support was one directional due to the woman's illness. For others, it was mutual despite the emotional challenges to their relationship. Most couples identified the father as the main source of support but highlighted the relatively minimal support network available to him. Freddy and Frances' experience was unlike that of the other couples. They drew their support from different members of their network and did not cite each other as the main support. Throughout the interviews with this couple a sense of resentment and tension between the partners was apparent. These were expressed in the differences in their understanding of their roles in the relationship and their response to Frances' illness (see comments for tables 16 and 18 above).

The support focussed consistently on the woman, with a significant number of helpers positioned in close proximity to her. The men's network was more limited and sparse. Helpers were also positioned at a greater distance from the man. This meant that these helpers were less likely to be utilised even if they were included in the potential network of helpers. Figure 14 illustrates this from an example of one of the couples, Lena and Len. They described their network in the following terms. Lena identified a strong line of support from Len, her health visitor and a group of local friends. Len was her main emotional support. Practical support from him was limited by his work commitments. Lena's initial professional contact was her health visitor, who discussed her concerns with her and referred her to the general practitioner. Lena continued to receive listening support from her health visitor once postnatal depression had been diagnosed. Her general practitioner was

perceived to be approachable and ready to listen. These attributes qualified her for inclusion in Lena's support network. Over time, local friends and a local parent group gradually developed into a source of support for Lena.

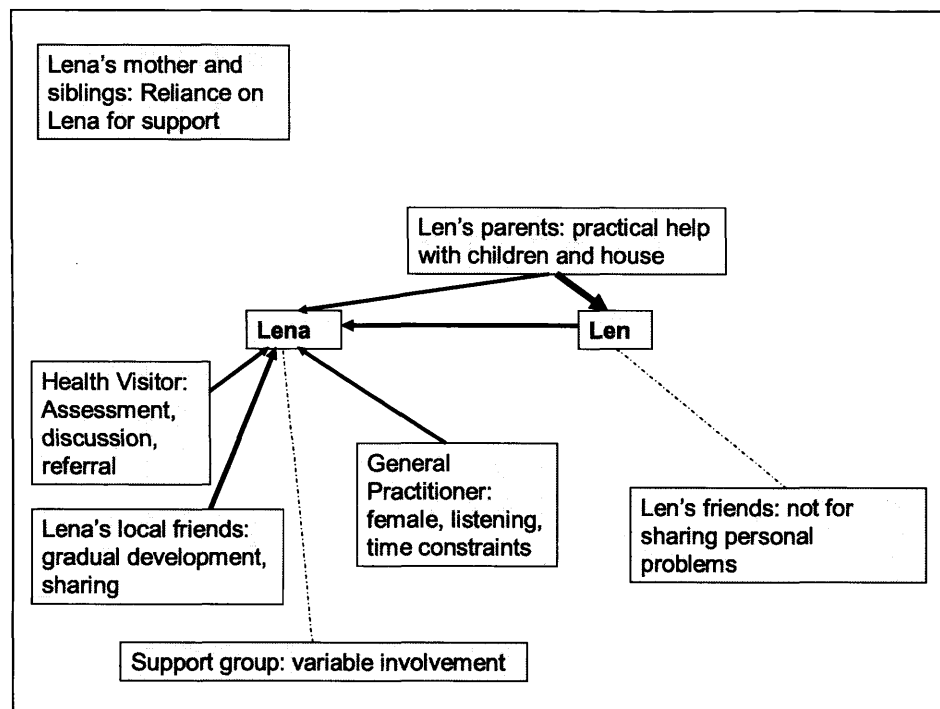


Figure 14 Sample support network

Both Lena and Len received substantial support from Len's parents. Although neither discussed Lena's diagnosis openly, Len's parents provided regular help with childcare and household chores. Len mainly relied on his parents for support to meet his ongoing work commitments during Lena's illness. Len's contact with friends was intermittent. Since personal problems were not discussed, these individuals remained on the periphery of Len's network. Lena perceived her own mother and siblings in similar terms. Her attempts to express her distress and seek help from them were unsuccessful. Lena placed them well outside the network.

Lena and Len's network reflects the experience of the couples interviewed in this study. A diverse group of helpers are potentially available to support the respondents. The woman is the focal point of each of the networks. Her partner is often her main support but frequently isolated from an effective support system himself. Any helpers identified by the men are more likely to have weaker links and are often placed at a distance.

The components described above were arrived at as part of the axial coding process of this stage of the analysis. This required not only further abstraction but also a return to the data and the original codes allocated to the data to check out the proposed framework. Each of the above categories consists of a range of subcategories and their components. These highlight the complex nature of the meaning of support from the couples' perspective. Similar elements are important for all respondents although the emphasis changes with each couple's unique circumstances.

6.5 Summary and conclusion

This chapter represents the second stage of the analysis of the data. Axial coding was used as the main tool to examine the hypotheses proposed in the first stage. The concepts identified earlier were further abstracted with a focus on the main areas of interest of this study. These two strategies represent an additional deductive as well as an inductive aspect of the analysis. Early hypotheses were first tested and reduced to a conceptual framework. The specific components of this conceptual framework were then

examined again for relevant links. The various subcategories thus identified were then summarised in the two category frameworks: the experience of postnatal depression from the couples' perspective and the related support issues. All of these elements eventually contributed to the development of the key processes proposed in this thesis and described in the next chapter.

Chapter 7 Findings stage 3: The core category and its related processes

7.1 Introduction

This chapter concludes the findings from the analysis described previously. It focuses on the two core processes proposed by this thesis: 'adaptation to a new normality' and 'process to seek help'. Selective coding was utilised in this final stage to achieve a further abstraction of the concepts. The focus is the description of the analysis of the data, which led to the formulation of these processes and their component elements. They capture not only the immediate experience of postnatal depression and the support needs of the couples, but link the elements into two overarching theoretical frameworks to inform care planning.

During the early stages of the analysis, the concept of 'normality' emerged as a key component. The couples compared their own parenting experience with that of other families. They utilised their definition of 'normality' to chart the progress of the illness and to make sense of their experience. The respondents identified their problem, sought help, reviewed progress and assessed recovery based on this definition. The concept of 'normality' captures the essence of the couples' experience of postnatal depression and constitutes the central category of this study. This core category is linked to the two processes, 'help seeking' and 'adaptation to a new normality', which illustrate the couples' journey through postnatal depression (figure 15). This

final stage takes the study one step beyond the core category towards the formulation of two associated process theories.

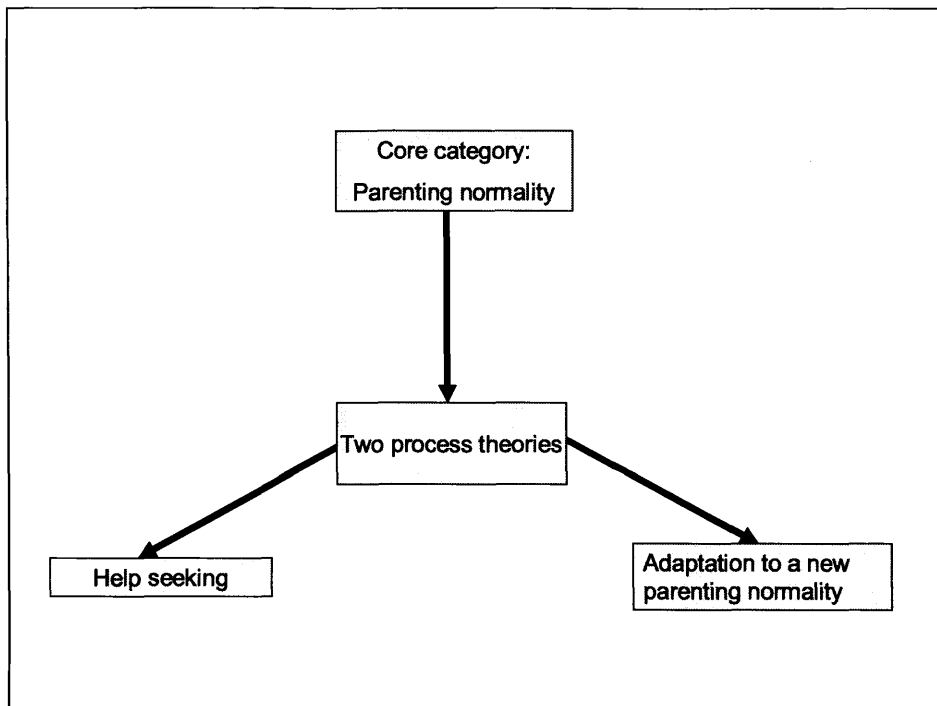


Figure 15 Core category and its related processes

The core category 'parenting normality' is described in more detail before it is linked to the two processes of 'help seeking' and 'adaptation to a new normality'.

7.2 Defining 'normality'

While exploring the experience of postnatal depression, the respondents frequently return to the theme of 'parenting normality' and how this informs their response to the illness. As one of the categories identified in stage two of the analysis, this category was explored in more detail. I returned to the data to seek a deeper understanding of the components of this definition and

its possible influence on the couples' understanding of their experience. The categories thus developed evolved from the previous findings and a further in depth analysis of the data. This task was guided by the following two considerations:

- What do the respondents consider to be the normal and abnormal aspects of their experience?
- Which comparisons do they utilise to inform this definition?

These questions were informed by the various dimensions of the category 'strive to achieve normality' described in stage 2 of the analysis. Figure 16 below illustrates the progression of this category identified in stage 2 via the two explorative questions to the definition of the couples' parenting normality.

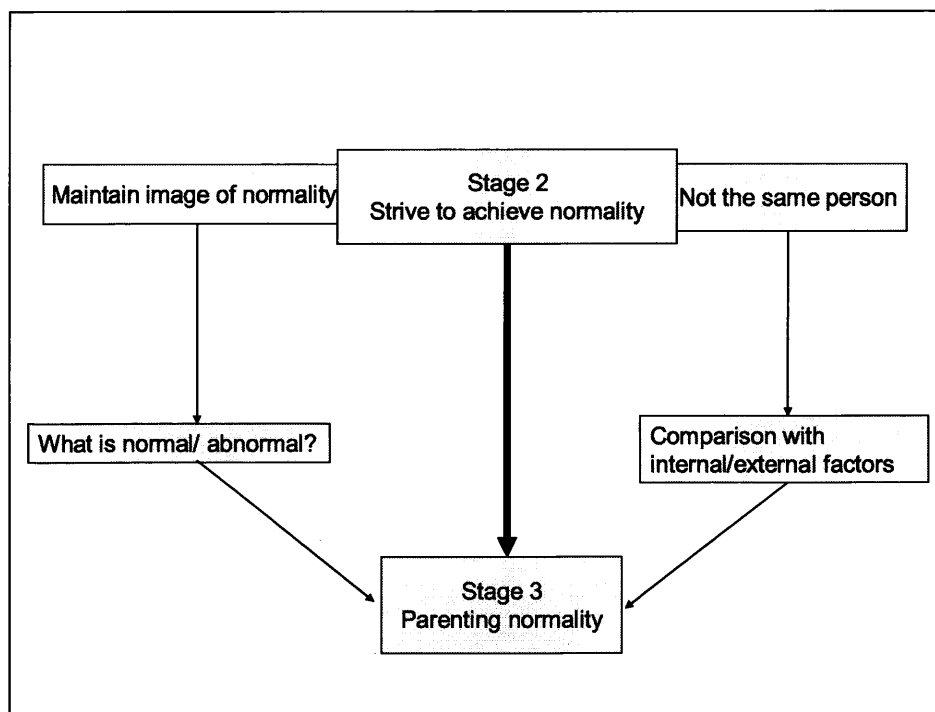


Figure 16 Defining parenting normality: analysis stage 1 to stage 2

Having identified a number of relevant categories, which captured the meaning of the terminology, I utilised selective coding to integrate these and define the core category of 'parenting normality'. Six aspects, which informed the respondents' definition of a parenting normality, emerged from the return to the data. These relate to the respondents' interaction with the baby and others, their perception of their parenting role and the external markers characteristic of a 'normal' person (appendix 10).

7.2.1 Interaction with the baby

The interaction with the baby is highly significant to the respondents, particularly the women. Couples expect 'normal' parents to be able to integrate the baby as part of the family, establish a routine and adjust easily to the child's presence. 'Normal' parents are able to enjoy the baby's company and leave the child with other carers. In contrast, 'abnormal' parents have difficulty adjusting to the new baby, are often tired, weepy and ineffective as carers. Jane compared her early response to her new baby with her expectations. Instead of a joyous, bonding experience, her first contact with her baby was unpleasant and intrusive. Jane frequently expressed her feelings of regret that she had been unable to act as a 'normal' mother should.

Jane, interview 4

You make things to be better than what they're going to be and when it's not, you feel let down. I thought we'd bond immediately.... but when he did it, I just thought well no, that's gross, he's all slimy. I want him [the baby] off of me

Often the women feel a sense of failure and regret. These unfulfilled expectations are informed by a desire to meet their own and society's standards based on their understanding of 'normal' mothering.

7.2.2 As a parent

For a 'normal' parent motherhood and childcare are perceived to be easy. The parent is competent and confident, although tired initially after having delivered the child easily and naturally. 'Abnormal' parents have to work at motherhood, tend to doubt their parenting abilities and are likely to have negative feelings towards the new baby and their other children. They are likely to blame the new baby for the illness. Nancy summarised the feelings of inadequacy and doubts about her skills as a parent, which affected her functioning and illustrated the implied expectation that 'normal' parents had no doubts about their abilities.

Nancy, interview 1

you doubt everything that you do with your child when you have postnatal depression; you doubt your skills as a parent

In addition, Karen highlighted the conflict presented by the perceived need to be both a 'good parent' as well as a 'good wife'. She felt that by meeting her responsibilities as a good wife, she was not able to be a good parent to her new baby. Kurt noted that this image of normality could have been distorted. Despite recognising that her expectations may have been unrealistic, Karen continued to strive to achieve them.

Karen and Kurt, interview 1

you also want to be a great wife and want to have the house perfect...

Kurt: Did you ever do it before like that?

Karen: No... but you still have all these things in your Even if you're being a great mum, you're not being a good enough wife. Or if you're being a good enough wife, you're not spending enough time with the baby.

The women in this study make every effort to meet a set of standards, which they often recognise as unrealistic and unachievable.

7.2.3 Interaction with the partner

The respondents' further utilise their definition of 'normality' to assess their relationship with each other. Care and empathy for the partner are components of a 'normal' relationship. The partners have a reasonable expectation that shared fun and activities provide the basis for a solid relationship. Couples under stress feel isolated and distanced from the partner. The relationship is unbalanced, characterised by unreasonable demands on the partners. Karen illustrated this in her description of the couple's stressed relationship. Although aware of the need to nurture their relationship, their 'normal' communication pattern was compromised and reduced to a minimum.

Karen, interview 2

I mean you know, you've got to put something into the relationship but it's really hard you just kinda, nod; everything is just too much, you know.

Kurt noted a sense of detachment and isolation, which all of the couples experienced at some stage of the illness. The relationship was under significant stress due to unfulfilled expectations of parenthood.

Kurt, interview 1

now not only are you detached from your wife I wouldn't have said I was disappointed having a baby but it definitely took a wee while to get used to.

Norman further illustrated this perception of distance, which differed from the couple's 'normal' expectations. He had made a decision to withhold important information from Nancy to protect her from additional anxiety. This strategy undermined the trust the couple felt was part of their previous, 'normal' relationship.

Norman, interview 1

it's like; why are you not trusting me, we've never kept anything from each other type thing,

The interaction between the partners is informed by a desire to maintain their previous relationship based on their definition of 'normality'. Even if the partners recognise that this definition is unrealistic, they continue to strive to meet this standard. This contributes to the stress felt by the partners and the tension in the relationship.

7.2.4 Social interaction with others

While the above aspects relate specifically to the interaction of the partners with each other and their child, the social interaction dimension focuses on the respondents' contacts outside the immediate family relationship. 'Normal' individuals are expected to be attentive to others, involved and able to interact easily with friends and family. Tolerance and a sense of closeness to others are 'normal' characteristics. In contrast, a sense of distance and isolation from friends are 'abnormal'. Bert for instance noted some of the

changes in Barbara's social interaction. She had been an outgoing person, who found it easy to meet others. Bert felt that her illness had made Barbara withdrawn and less confident socially. As she began to recover, she returned to her previous 'normal' confident self.

Bert, interview 3

she became less inclined to, interact in conversation. now you're just as at ease starting a conversation with somebody than waiting.

Frances noted similar feelings. She contrasted these against her 'normal' abilities to interact easily with a range of people in a busy job. Leaving her house and meeting others in her local village became very difficult for her.

Frances, interview 4

I did find it extremely hard to go places and do things and yet I'd always had a sort of busy job where I had a lot to juggle and cope with

The respondents utilise their definition of 'normality' to assess their functioning in their wider social sphere. The women, in particular, lose confidence in their interaction with others. They contrast their ability to meet others before and after the onset of postnatal depression. Only when they begin to recover, are they able to resume social contacts and regain their previous 'normality'.

7.2.5 Characterising the normal person

When the respondents define the characteristics of a 'normal' person, they identify both desirable and undesirable attributes. Being in control, independent and coping conveys a sense of strength and sociability. Feeling

happy and being 'bubbly' are desirable attributes of a 'normal' person. A 'normal' person can experience a range of moods but these remain within acceptable boundaries. The 'abnormal' and thus undesirable person is at 'rock bottom', is uptight and finds it difficult to relax. Extremes of mood are as undesirable as a lack of variation. The latter is characteristic of a 'plastic' person. Chris for instance found it difficult to accept Carla's extremes of mood. He found these inappropriate and hurtful but was prepared to accept them from his ill partner.

Chris, interview 4

She was horrible.... if she'd been a man I'd have lamped her, some of the things she said to me because she was horrible to me.

While Chris found these mood swings difficult to manage, Paul considered some changes in Pam to be desirable and 'normal'. He felt that unpredictability was an attribute of Pam's 'normal' persona. This had been lost due to the effects of her medication and was particularly apparent in the loss of physical intimacy and spontaneity.

Paul, interview 3

it gets difficult to live with somebody who's on them because there's no ups or downs and it's too bloody predictable..... It's a bit plastic.

The couples further assess their progress and recovery from the illness against the criteria, which define 'normal' and 'abnormal' life for them. 'Normality' is characterised by an acceptance of change, calmness and a new impetus to plan ahead. The latter can be an indicator of recovery or indicate an adjustment to living with a more chronic illness. A sense of being

able 'to get on and do things' represents hope of recovery. For Carla, permission to return to work was a major milestone. Although she had felt better for some time, her return to work indicated for her a return to 'normal'. She only saw herself as a complete person if she was able to participate fully in the workplace and function effectively outside the home environment. She stated that she enjoyed her time spent with her children, but her comments suggested that she also needed affirmation of herself through her professional work.

Carla, interview 4

I'm starting back to my work I'm so excited, so excited. to get everything sorted and really chuffed

The re-emergence of 'normal' personal characteristics in the woman further measures her recovery. Evelyn's restored sense of humour and enthusiasm in her daily activities indicated this. Although postnatal depression had become chronic depression, this was a positive step. The couple felt more positive, measuring progress against these personal indicators of 'normality'

Edward, interview 4

see her sense of fun and all the rest and seeing her talking about, relating what has happened during that day..... just seeing that again, hearing that is really good.

Various personal characteristics inform the couples' definition of 'normality'. The woman's illness and her recovery are judged against these criteria. Extremes of mood are as undesirable as a lack of variety. Returning to work and engaging with other interests are indicators of recovery and a return to 'normality'.

7.2.6 Comparison with other markers

The respondents' definition of 'normality' is informed by personal standards and social expectations. They compare the woman's relationship with her family prior to the child's birth and after postnatal depression. Both partners utilise their knowledge of the woman's previous self and compare this with her relationships after the birth of the child. This knowledge of the familiar attributes and characteristics of the woman inform the definition of 'normality'. Mike described his bewilderment generated by Maureen's illness. He contrasted her ill self, crying frequently and lacking interest in a range of activities, with her previous happy and outgoing self. He was puzzled by the sudden and unexplained change in her.

Mike, interview 1

it knocked me for six fair enough everyone has their ups and downs she's just not interested in a lot of things she used to be, a very bubbly person and all of a sudden it just, you know, changed.

Comparisons are also made with other mothers and families. Olive and Pam's observations of others outside of the immediate family generated a sense of inadequacy and reinforced their feelings of low self esteem and failure. It was important for Olive to be seen to meet the expectations of others. She felt that 'normal' individuals were able to manage parenthood more effectively than she did.

Olive, interview 4

I used to worry a lot about what other people thought to keep up to...things that other people coped with that I didn't

Pam expanded on Olive's comment. She noted that her own sense of failure was strongly informed by her comparison with other, more 'normal', individuals.

Pam, interview 1

you see all those other people going down the street with a smile on their face andyou think, well why can't I just be that way as well?

In addition social expectations of family, friends and, at times, the media contribute to the 'normal' image of parenthood. For instance Dana and David felt that 'normal' parents were happy and relaxed. Their own experience with their fractious child did not meet their expectations and was seen to be abnormal. They attributed this perception to outside agencies such as parent craft classes and the media. Their parenting experience with their second child was significantly different and matched their image of 'normality'.

Dana, interview 4

I can remember thinking this is why people like babies, this is why new mums look happy I just couldn't believe it how lucky we were

While parenthood requires a period of adjustment, changes become 'abnormal' if they persist beyond a certain time, usually 3-4 months after the child's birth. The couple's experience of parenthood should match their definition of parenting normality both within and after this time. If the couple feels that their experience is 'abnormal', they begin to consider alternative explanations.

The couples' definition of 'parenting normality' is based on a number of factors. Some of these are internal to the couple while others are external.

The internal aspects relate to comparisons with the self at various stages such as before and after the arrival of the baby, before and during the illness and on the way to recovery. Their previous experience and the partners' expectations of the woman further influence the couple's comparison with their current experience. The external factors reflect the expectations of others as perceived idealised image of parenthood. These are conveyed through the behaviour of family, friends, professionals or the media and influence the couples' expectations of themselves and their experience.

Table 29 summarises the different comparison, which inform the definition of 'normality' based on internal and external factors.

INTERNAL FACTORS	EXTERNAL FACTORS
SELF: Attributes Behaviour Characteristics	IDEALISED IMAGE: Own expectations Media presentation Parenting classes
BEFORE AND AFTER BABY: Personality Relationship with- partner/ baby	EXPECTATIONS OF OTHERS: Behaviour Talk Observation

Table 29 Comparisons to define normality

This image is not an objective interpretation of the woman's behaviour, her characteristics and her relationship with the partner and child. It is important that these perceived characteristics are utilised to manage the illness and sustain the relationship. The characteristics of the woman before the illness are described in positive images such as 'she was always bubbly', outgoing, in control but also fiery, moody and moaning. They allow the partners to identify the difference between their experience during the illness and what

went on before. For instance the extent to which the partner is outgoing or temperamental determines the couples' judgement of the level of severity of the illness. Oscar and Olive strove to return to their previous 'normality' but also recognised the effect of a new baby and postnatal depression on this process like Oscar and Olive.

Olive, interview 1

I think I'm forgetting that everything's always been done but I'm still trying to do that as well as look after 2 children as well.

Lena and Len challenged the legitimacy of a definition of 'normality'. They suggested that parenthood itself was inherently a process of adjustment. Postnatal depression was not interpreted by them as an illness but a delayed adaptation to this new experience. They brought the concept of normality into question and placed recovery from postnatal depression outside the medical domain.

Lena and Len, interview 4

Len: I don't know that it's normality, just that it's different ...

Lena: It's a different normality isn't it?

Len: Yeh, it's acceptance, acceptance, it's different,you weren't sure whether you were postnatally depressed or whether it was just the fact that normality is sort of shifted over here and ... you were expecting things to have been over here. And what is "normality"?

Defining a 'normal' experience of parenting is thus a key consideration for the respondents. It informs their attempts to make sense of their experience and determines how and when they decide to seek help. As the illness progresses, they judge progress and recovery by the definition's criteria. The uncritical acceptance of the need for a definition of 'normality' is not

necessarily advisable and needs to recognise the various factors, which influence the experience of parenting. The parents in this study strive to meet a range of expectations. In the process, they question a narrow interpretation of postnatal depression as an illness and suggest a process of adaptation towards a new normality.

7.3 Linking the core category to its related processes

Strauss and Corbin (1998) encourage the researcher to focus the analysis on one key aspect. The couples' definition of their 'normality' for me represented such a core category. This only partially reflects the complexity of the issues presented by the respondents. While the core category is populated by the various categories identified throughout the study, its linked processes reflect the dynamic nature of the interaction between these components. All three elements interact with each other and inform our understanding of the experience of postnatal depression from the couples' perspective (see figure 15 above).

To integrate the core category with its related processes, I utilised two of Strauss and Corbin's (1998) coding tools: writing the storyline and making use of diagrams. These storylines are outlined in the next part of this chapter. They inform the subsequent development of the two conceptual diagrams, which capture the relationship between the various elements. Representing them in diagrammatic form facilitates abstraction and provides an overview of the relevant key concepts. This helps to explain how the couples utilise their definition of 'normality' to seek help and adjust to a new normality. Since the

diagrams emerged from the storylines constructed during this final phase of the analysis they are presented at the end of each relevant section (see figures 17 and 18 below). They thus provide a summative overview of the findings and conclude this stage of the study.

7.4 *Process to seek help*

The couples describe the process to seek help as taking place in two stages. Stage one is situated within the internal system of the couple, close family and friends. Stage two moves the process outwith this immediate network into the external world of professional organisations, voluntary groups and casual acquaintances of the couple.

7.4.1 The internal system

7.4.1.1 Unease and symptom check

The respondents report a number of considerations, which gradually emerge from their assessment of 'normality'. An undefined feeling of unease leads them to check out the woman's symptoms against their perceived 'normality'. The woman discusses these with her partner, close family and intimate friends. This is an attempt to assess whether her feelings of unease and low mood are part of 'normal' parenting or may indicate more significant pathology. At this stage, both partners are inclined to seek out normalising explanations based on biological causes such as difficult childbirth experiences, tiredness, fretful baby and the physical after effects of childbirth.

7.4.1.2 Difficult to admit

A tendency not to admit to the presence of a potential problem exists. This is often driven by feelings of guilt that the woman is unable to meet the expectations of the 'normal' good wife and mother. Disclosure of these feelings can cause a dilemma for the woman. Although she feels uncomfortable, she finds it difficult to admit to her difficulties. Often her partner is more aware of her problems than she is able to acknowledge. In this situation, the woman needs to be able to trust in the judgement of her partner and others. This is often only possible once the woman herself has been able to admit to herself that she needs help.

7.4.1.3 Effect on the relationship

For most couples the realisation that the relationship itself is being affected by her symptoms, progresses help seeking from stage one to stage two. The symptoms are discussed more openly. Others outside the immediate couple relationship are approached for help. For some women a crisis point is reached, which acts as a trigger to open up to external sources of help. Karen describes such a trigger event. She had been able to manage her increasing feelings of unease for a considerable time. Kurt's departure to visit his sick father prompted her to acknowledge her feelings openly and approach her general practitioner for help.

Karen, interview 1

I just felt when he left that I just couldn't cope. I felt like that before he left but it was that weekend while he was awayI didn't want to go on. ... "I'm not a good enough mum and I'm not coping with this I knew I needed to go to the Doctor's and get proper help

Other women realise more gradually that parenting is not progressing as expected. Comparisons with other mothers inform the definition of 'normality' and subsequent help seeking.

While these considerations make up the first stage of help seeking, they do not occur in a linear manner but are visited by each partner and by the couple over a period of time. Concern for the other partner and the welfare of the children, a helper perceived to be approachable and a previously positive support experience aid this process of recognition. Feelings of inadequacy, a desire to manage independently and a fear of the stigma of mental illness can impede progression. The process leads to the realisation that the couple's experience is not 'normal' and appears to differ from that of other families in a similar situation. This stage is characterised by an internal dialogue and the search for answers within safe systems. Helpers, who are perceived as trustworthy and close to the partners, can facilitate this process. The couples gradually widen their search for help towards sources external to the immediate couple and family relationship. Doubts about whether the woman's experience is 'normal' or 'abnormal' can delay help seeking from these external helpers. At this exploratory stage, helpers are valued for their trustworthiness and their ability to establish a relationship rather than their professional role. This allows the woman to confide in the helper based on a feeling of mutual trust.

7.4.2 The external system

7.4.2.1 Hand over control

When this internal dialogue has been completed or is brought to an end, sometimes due to a crisis, the couple approach external helpers, often a health visitor or general practitioner. Karen illustrated the progression from the internal to the external system of helpers. Having initially attempted to manage her difficulties, she felt the need to function effectively for the benefit of her child. She explored her concerns with a range of people such as her partner, her mother and eventually health professionals. This joint decision making process led to her decision to approach her general practitioner for help.

Karen, interview 2

because I had a baby, I thought "No. This is no good. I've got to be on the ball and I've got to be okay for her.... what the Health Visitor said to me and the Doctor, ... and ... my mum we all agreed it was the best thing to do would be to go to the Doctor's and before it got any worse as well.

At the same time such a move can be fraught with risk. It involves the disclosure of the difficulties to others outside the family system and hands over control to outsiders. These considerations affect the woman's approach for help and cause additional distress, reinforcing her feelings of inadequacy and vulnerability.

7.4.2.2 Relief mixed with guilt

Approaching others for help becomes highly significant for the respondents. The decision to do so is further influenced by the characteristics of the

potential helper such as trust and approachability. When a professional is perceived to be unapproachable and not interested in her difficulties, the couple do not feel able to utilise this potential resource. Pam's comment illustrated this as one of the factors, which affected the couple's decision to access help outside the internal family system.

Pam, interview 1

And I always felt she was in a bit of a hurry anyway, so I shouldn't sort of burden her up with my problems, should bother her.

While disclosure to outsiders allows the woman access to treatment, the feelings of relief are mixed with concerns over the stigma of a diagnosis of mental illness. Lena was relieved to receive a diagnosis, which gave her access to treatment and provided a tangible explanation for her difficulties. It also gave her permission to accept support from others.

Lena, interview 2

once they put a label on it ... It's maybe because I'd got a reason for it andmaybe me sort of let down the hackles a bit and let everybody in more.

As the internal dialogue progresses to include other helpers outside the immediate relationship, it is subject to a number of complex considerations. The respondents feel a sense of relief when they are able to share their concerns, which allow them to access appropriate help. At the same time, feelings of guilt and a perception that outside helpers are not approachable can impede this process.

7.4.2.3 Stigma of diagnosis

In addition any feelings of relief can be influenced by a sense of embarrassment related to a diagnosis of mental illness. Nancy commented on this perception of secrecy, which she felt surrounded the illness. Her conversation with other women supported her view that the illness was not discussed openly among her peers. This stigma created feelings of shame and discouraged approaches for help.

Nancy, interview 2

a number of women I've spoken to that have gone through it, yet you would never know because they don't talk about it... so I think that's why you feel ashamed.

Similarly to the internal process to seek help, this external aspect is not linear and is influenced by a number of considerations. These are based on the respondents' expectations of support, the knowledge of the characteristics of the potential helpers and the services, which are potentially available. The couples make their decision based on their comparison with the 'normality' of their peers and their own knowledge of the support available. If their previous experience has been unsatisfactory, the couples adjust their expectations accordingly.

7.4.3 Summary

The process to seek help within the context of postnatal depression is characterised by the complex interaction of a number of factors (figure 17). It contains the three components of time, the internal couple and family system and the external system of non family helpers. As time passes after the birth of the new baby, the couple check early feelings of unease against their

definition of parenting 'normality'. Feelings of guilt and a reluctance to admit to the existence of a problem occur at this time. These considerations remain internal to the couple and a few selected intimate helpers. A perception that family relationships are negatively affected can prompt action and the search for help from the wider support network and professional helpers.

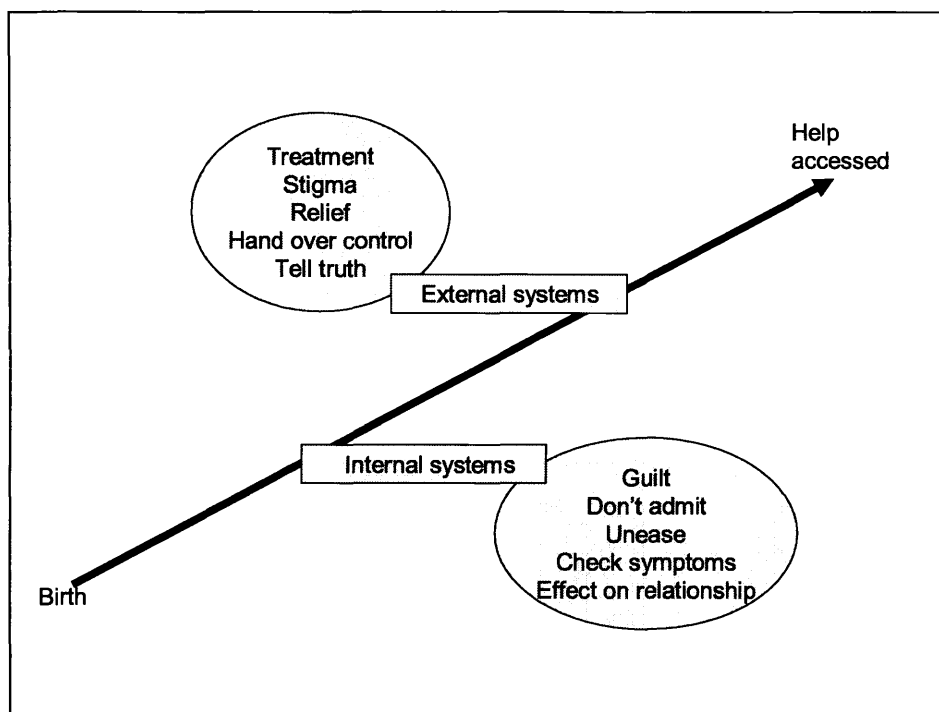


Figure 17 Process to seek help

Opening the internal system to this external scrutiny can have mixed results. While it can generate feelings of relief and provide access to treatment, the woman also has to disclose her feelings to others and hand over control of some aspects of her life. The significance of a potential diagnosis of mental illness and its associated stigma further influence the decision to approach external helpers. The respondents describe help seeking as a staged process which moves them from early feelings of unease expressed within

the internal system to help from professional workers external to the family. During this process they make decisions about the need to seek help, when to expand the circle of helpers and whether to share their need for support with them.

7.5 Process of adaptation to a new normality

7.5.1 Considerations

While the process to seek help is a central component of the couples' ability to manage their experience of the illness, a concurrent process of adaptation to a new normality occurs. This allows the couples to progress from their experience of early parenthood and postnatal depression to a new understanding of the illness and their relationship. A number of considerations and support issues impact on this process: the representation of postnatal depression, the respondents' feelings, their expectations and their existing coping mechanisms. These components are informed by the couples' internal value systems and experiences. Support issues such as the characteristics of the helpers, the conditions under which help is offered and the treatments available further influence the progress towards a new normality. They are external to the couple relationship and perceived to be outside the individuals' control.

7.5.1.1 Representation of postnatal depression

The representation of postnatal depression and the couples' perception of causality of the illness influence the process of adaptation. If the perceived cause of the illness is physical, then often the partner feels more able to

understand and support the woman through her illness. When the respondents perceive the cause of the illness to be physical, they are able to access known management strategies familiar to them from other life situations. Couples with previous experience of postnatal depression are less likely to speculate about the causality of the illness. They are able to draw on existing management strategies. Various coping mechanisms are utilised, which aim to control the shift in 'normality' and facilitate an understanding of the woman's illness and her needs.

Mike, interview 3

if the post natal depression's out of the way...we're going to come together and be a lot happier. there is this thing that's sort of in the way and we need to sort of clear it up.

Mike's comment reflected his desire to resolve difficulties and to adapt to the changes brought about by the illness. His response highlighted the importance he and the other couples placed on an early resolution to benefit the couple relationship.

7.5.1.2 Existing coping mechanisms

Having trust in the other partner and sharing feelings are useful strategies to manage this shift in the relationship. Trust can be compromised due to a false desire to protect the other partner. Men, in particular, report that they cope with the changed relationship and the related emotional issues by 'putting things on the back boiler'. This can lead to a breakdown in communication and isolation from the other partner. Norman commented on this loss of trust. His desire to protect Nancy from additional anxiety had

compromised the couple's relationship. Norman reflected on his previous coping strategies during this interview. In retrospect he felt that this had not been an effective way to manage the problems and regretted the loss of trust this had caused. The couple had subsequently worked consciously on building openness into their relationship. This was one aspect the couple returned to during the last interview after six months. They were planning for the expected arrival of their second child and considered their strategy in response to a possible recurrence of Nancy's depression.

Norman, interview 1

the fact that I withheld information I think probably made it worse, it made her maybe realise, "oh my god what's he doing not telling me this!".... it's like why are you not trusting me, we've never kept anything from

Some existing coping strategies can be useful to manage the change in the couple relationship. Others, such as emotional withdrawal and a desire to protect the other partner, can compromise mutual trust and communication. The couples appear to be aware of the various coping strategies available to them but tend to rely on those most familiar to them from their previous experience. They speculate about possible alternatives to their own coping strategies and consider how these might have affected their response differently.

7.5.1.3 Anticipated timeframe

In addition the anticipated timeframe of the illness affects the couples' response. There is an expectation that any difficulties are likely to resolve within a few months. Even if this anticipated time period is exceeded, the

couples continue to readjust their expectation. This allowed them to persevere over sometimes an extended period of time. Although the respondents want to return to their previous 'normality', they recognise the need to negotiate and adapt their relationship to the demands of the illness. This often involves putting issues on hold, in particular the sexual aspects of the relationship. Short-term disruptions to the relationship are managed with relatively little difficulty. If the illness develops into a more long term or even chronic illness, adjustments to the relationship need to be made. These are more complex, put the relationship under considerable stress and lead to the realisation that a return to a previous normality may not be possible. Paul described this sense of unease, which the changing timeframe of Pam's illness generated. He talked about the feelings of helplessness and fear that a recovery might not be possible.

Paul, interview 3

It was the worst thing because the time scale just kept going on and on It started getting to a point where you're thinking, is it gonna get any better?

Pam and Paul's subsequent dialogue illustrated their gradual adjustment to these changed expectations. They adapted gradually to a new 'normality', which allowed them to manage their difficulties. Despite ongoing challenges, the couple felt that Pam had made progress.

Pam and Paul, interview 4

Pam: the depression is still there.

Paul: Yeah but you went out with a friend last week and you were in a pub and there was an awful lot of people there so it was no you've gotta go

The anticipated timeframe of postnatal depression affects the couples' adaptive process. They expect short term difficulties to resolve and an early return to their previous 'normality'. Long term problems require a change in perspective to adapt to a new 'normality'.

7.5.1.4 Feelings

The representation of the illness, existing coping mechanisms and the anticipated timeframe of the illness are closely linked to the process of adaptation. They influence how the respondents assess the illness and manage its progress. In addition the respondents' feelings for each other and their attitude to the relationship, contribute to this process. A key component of the couples' stories is the considerable long-term impact, which the illness has on the relationship. Respondents interviewed a number of years after the resolution of the illness, comment on the distress and challenge to their relationship. For instance both Evelyn and Edward and Frances and Freddy had first experienced postnatal depression approximately seven years previously. Both couples were able to recall their experience vividly and commented on the impact of the illness on their relationship.

The experience generates strong feelings in the partners such as a sense of distance due to a breakdown in communication. The desire to protect the other partner from painful information, such as the expression of suicidal feelings, can contribute to feelings of isolation. An inability to understand the needs of the ill partner and offer effective support leads to feelings of frustration. Both partners can feel rejected emotionally and physically. The

men expressed feelings of sadness and depression as well as anger with perceived unreasonable demands. David for example felt frustrated with the change in the couple's relationship.

David, interview 3

it was a bit frustrating when she didn't acknowledge the fact that you were helping and the fact that she was very cross with me ... she was keeping me at arms length.

Postnatal depression causes a noticeable change in the couple relationship. The partners have contemplated the possibility of breaking up at some time due to the strains imposed by the illness. While these negative feelings can hinder the process of adaptation, feelings of love and affection between the partners have a positive effect and can help the couple overcome significant difficulties. The partners try to protect each other from emotional distress and further upset.

The men seek solutions to fix the problem. They feel frustrated, if their offers of help and support do not appear to make an immediate difference or result in a negative response from the partner. These challenges affect the couples' process of adaptation and the long-term survival of the relationship. The successful outcome of the process of adaptation is driven by an underlying perception that the relationship is important and worth saving. This judgement is based on the previous knowledge of the partner, feelings of affection or a sense of common responsibility for the family. Jason summed up this strong sense of commitment. Despite some significant personal and emotional challenges, he decided to work at his relationship based on his

deep feelings for his partner. He recognised the need to adapt to this new 'normality' but also saw this process as temporary and time limited. He was encouraged by a sense that his efforts would help to resolve the couple's difficulties and return them to a previous 'normality'.

Jason, interview 4

my life would be nothing without her or [the baby] so I have to work at it and work at it and that at some point it's going to ... disappear

In addition the experience can provide an opportunity to re evaluate the relationship and reaffirm the partners' commitments to each other. Len felt that the new normality for him and Lena was a strengthened relationship rather than one of transition and continuous emotional challenge.

Len, interview 4

I don't think the relationship ever got bad. I mean, if it's possible to go from better to even better, then that's probably how it is, isn't it?

The differences in perception reflected by these two couples could be attributed to their very different ages. Jason and Jane, the youngest couple, were facing their first challenge to their relationship. Len and Lena, one of the older couple, had significant life experience behind them and had managed a number of family difficulties. Their responses illustrated the continuum of emotional transitions experienced by the couples, ranging from a perception of temporary change in the relationship to one strengthened by adversity.

Postnatal depression generates a range of feelings in the respondents, which remain long after the illness has been resolved. These include a loss of

intimacy and sense of frustration. A desire to maintain a valuable relationship can help the partners meet these challenges.

7.5.2 Support

In addition to these considerations, the process of adaptation can be facilitated or hindered by various factors related to support issues. These are mainly the attitude of the potential helpers, the conditions under which help is accessed and the treatment options available to the couple.

7.5.2.1 Helpers and their attitudes

The attitude of the potential helper can affect the process of adaptation. Help is dependent on the ability and willingness of the helper to acknowledge the difficulties experienced by the couple and their need for support. A lack of recognition due to various social or cultural factors acts as a barrier to this help. Negative family dynamics affect problem recognition and exclude the family from supporting the couple. This can affect the women's progress through the illness, potentially isolating the partners from sources of help and slowing recovery. Particularly Karen and Kurt and Lena and Len noted that they used their previous experience to exclude some close family members from their network of potential helpers. Positive attitudes from family and friends can facilitate the progress towards recovery more easily, making help available in both practical as well as emotional terms.

The attitude of professional helpers further affects recovery and the couple's adaptation to a new normality. They can provide valuable diagnosis,

treatment and support. Working jointly with the couple, they can provide information on the condition and its management, help to explore treatment options and encourage compliance with treatments. In contrast, limited resources, differences between medical and lay perspectives and a disempowering attitude from the helper can hinder the process of recovery and adaptation.

7.5.2.2 Conditions

The conditions of support further affect the couples' process of adaptation. These relate to the characteristics of the various helpers, the format of the help and its outcome. It is important that the recipient of support is able to recognise and accept the help available. When these conditions are met, a range of support options becomes available. Olive for instance described her change in attitude towards her partner, Oscar. She was initially unable to accept practical help but gradually became more tolerant.

Olive, interview 1

Yeah, it's very unreasonable and I know that now you think he should be able to do all that but you never give him the chance to do it so how is he going to learn?

A number of conditions affect the journey towards a new normality. This is characterised by external factors such as the availability and attitude of the helper but also by internal factors such as the readiness of the woman to accept the support.

7.5.2.3 Treatment

A final consideration, which affects the process of adaptation, relates to the range of treatments available. Positive influences on this process are a choice of treatment options, social contacts and the opportunity to share the experience with others. Medication is generally seen as part of the solution, but not necessarily a first option. Both partners, but the men in particular, prefer being included in the decision-making process as noted by Paul.

Paul, interview 1

as a man, you don't really have a clue what's going Just pushed over to one you'll be all right in the end but we're not telling you how or why

The men appreciate the opportunity to discuss their concerns with a knowledgeable person to understand and manage their partner's illness. This can take the form of a single information session or more formalised counselling. The women also cite talking solutions to help them contextualise their personal experience and facilitate the process of recovery and adaptation.

In addition the men express a preference for individual rather than group support. They seek out female family members or close friends for advice. Both partners express a need to check out their experience with others, to obtain information about the illness and explore their feelings. Richard expressed this need to gain information and explore his feelings. He commented on the potential for self doubt and changes in the relationship generated by Rachel's illness.

Richard, interview 3

it's information to start with and then the counselling acts as a follow through because... there will be self doubt 'Am I still with the right person, she's not who I married, she's changed'

A range of considerations and a number of support issues influence the process of recovery and adaptation to a new parenting normality. How much each factor influences the process of adaptation differs from couple to couple and is, among others, dependent on the couple's previous experience, their personal attitudes and the help available to them.

7.5.3 Outcome for the couple relationship

The process of adaptation to this new normality is completed for some couples when they feel that their relationship has returned to that experienced prior to the illness. Although an adjustment is made to include the new baby, the respondents are able to relate to each other as they did prior to the onset of her illness. Karen summed up this return to a previous normality, but even this normality was only 'kinda ish normal'. The couple felt that they had overcome their emotional difficulties and adapted to the presence of the new baby.

Karen and Kurt, interview 4

Karen: Things have gone really well... seem to kinda be back to the way we were, ... there is a baby now, you know, and my hormones have settled ...It seems to all kinda calmed down so now it's kind a

Kurt: Back to normality.

Karen: Back to normally kinda ish.

Other couples feel that their relationship has changed and adapted to a new 'normality'. Minor adjustments include the redistribution of childcare

responsibilities, a return to work or the start of new activities. Some need to modify their relationship to manage the chronic depressive illness, which has developed from postnatal depression. In this case, the partners need to re-evaluate their core values substantially to take account of the long-term implications. Richard's strong commitment drove his desire to seek solutions to manage Rachel's illness. Rather than abandon the relationship, he set new goals, which reflected the couple's new 'normality'.

Richard, interview 3

I want to spend the rest of my life with Rachel, she wants to do the same with me and we've learnt to re-evaluate what our own goals are,

Richard and Rachel's and Evelyn and Edward's experiences are examples of the furthest end of the adaptation process. Their experience illustrated the variety of stress reducing activities, which the couples utilised to adapt to the symptoms of a chronic illness. These included strategies to reduce work related pressures on their lives and to adjust their social aspirations. Rachel and Richard chose less demanding employment, while Evelyn and Edward planned their social activities around Evelyn's depression. Although postnatal depression had developed into a long-term depressive illness, they had adjusted their expectations to define a new 'normality'.

When the process of adaptation is successful a journey of developmental growth is completed. Karen elaborated on her earlier thoughts, reaffirming the core values of the relationship. This was more important to her than what she termed the 'trivial' daily chores and concerns.

Karen, interview 4

I've kinda stopped kinda thinking about everything in such a kinda extreme way. you kinda, learn not um getting irrational about trivial things because it'll all be there tomorrow.

Bert also described a similar adaptation and an improvement to the couple's relationship, which had developed in a positive direction.

Bert, interview 4

now, you know, it's a lot more relaxed and I think we enjoy each other's company even more now.

The process of adaptation represents a central component of the experience of postnatal depression. It reflects the journey towards recovery and results in a redefined new 'normality' on successful completion. This may or may not equate with a full recovery from postnatal depression. Such a re-definition occurs even when the illness has become a chronic depression.

The process of 'adaptation to a new parenting normality' is the third component in this final stage of the analysis (figure 18). The progression from the child's birth and early stages of the illness towards recovery is different for each couple, is not linear and influenced by a range of factors. Various considerations inform the respondents' assessment of their experience and their evaluation of the resources available to support them. Some are internal to the couple relationship such as their existing coping mechanisms and feelings. Others relate to outside factors such as the helpers available and the treatments offered. For all respondents, this process of adaptation reflects the considerable challenges, which the couples have to overcome to

remain together. Like the ‘process to seek’ help, the ‘process of adaptation’ is informed by the respondents’ definition of their normality.

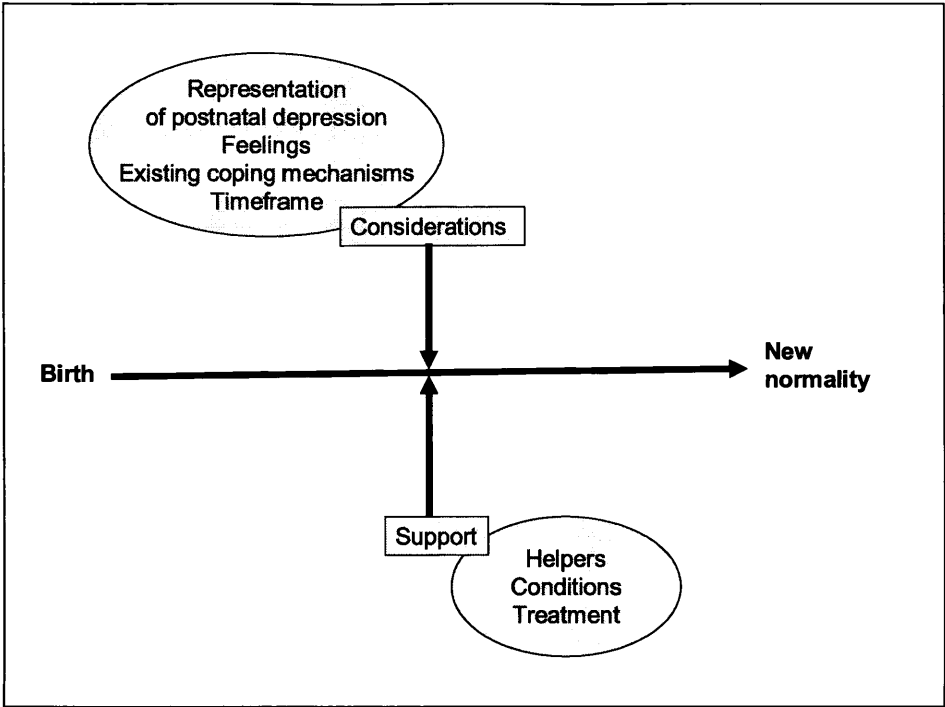


Figure 18 Process of adaptation to a new normality

7.6 Summary and conclusion

This chapter represents the final and third stage of the analysis. The categories identified in the two previous stages were utilised to inform the core category of parenting ‘normality’. It is central to the experience of postnatal depression and the respondents’ assessment of the various sources of support. The core category was identified by revisiting the earlier categories, re- evaluating their dimensions and condensing the concepts. The respondents define their parenting ‘normality’ based on a range of factors. These include their relationship with the new baby, their partner and

comparisons of their experience with others outside the immediate family. While this definition is central to the couples' experience, it also informs the related 'process to seek help' proposed by this study.

Not all couples were at the same stage of the illness when they participated in the study. Some were able to contribute their stories of recovery from the illness as an additional dimension. These narratives contributed to the development of the 'process of adaptation to a new normality'. This was informed by the respondents' definition of their 'normality', their existing coping mechanisms and other considerations.

The two processes complement each other and represent two aspect of the continuum of the experience of postnatal depression. The first offers an insight into the couples' consideration of the early symptoms and its influence on the management of the illness. The second describes some of the factors, which contribute to the respondents' progress through the course of the illness towards recovery and a new 'normality'. The respondents' definition of their parenting 'normality' is central to the couples' experience. It informs their decision making at various stages of the illness and charts their path to recovery.